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Survivors' Perspectives on Helpful and Hindering Impacts when Healing from Childhood Sexual Abuse

by

Mary Elizabeth Pudmoreff ©

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Dedication

To the survivors who openly shared of themselves and their experiences so that this research could be conducted. Thank-you for being willing to risk and to share so that I, and others, may better understand healing and hindering influences to healing.

To survivors everywhere—I offer this research to assist you in your healing process.

To my children—and all children—with the prayer that you will be protected from abuse throughout your life.

To Sam. Clearly you have influenced who I have become. I like who I am. I want you to know, I forgive you.

Acknowledgement

Although this research may have been conducted by a single investigator, its mere existence is testament to the wonderful support system that I am blessed to have in my life. Without the support of many individuals this research would never have occurred.

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Although my boys Elijah and Joshua are too young to understand "dissertation", they have certainly come to know what the phrase "Mommy has to do homework" means. To them, I say "Thank-you for being so patient" and "Good news: Mommy's done! No more homework!"

Mostly, I thank the Lord for blessing me with such wonderful people in my life!

Table of Contents

Chapter 1: Introduction **1**
Definition 1
Prevalence of Childhood Sexual Abuse 3
Characteristics of Childhood Sexual Abuse 6
    Socioeconomic Status (SES) 6
    Racial/Ethnic 7
    Age 7
    Gender 8
    Perpetrators 9
Significance of this Research 10
Chapter 2: Literature Review **11**
Consequences of Childhood Sexual Abuse 11
    Short Term Effects 11
    Long Term Effects 13
    Attachment and Sexual Abuse 16
    Intervening Variables 19
        Abuse Specific Variables 20
        Child-Related Variables 21
        Environmental Variables 22
    Summary 22
Overcoming Childhood Sexual Abuse 23
    Helpful Impacts 24
    Hindering Impacts 25
    Helpful Therapy Impacts 28
Implications of Existing Literature 33
Chapter 3: Methodology **38**
Concept Mapping: An Overview 38
    Generating Ideas 38
    Grouping of Ideas 39
    Analysis of Data 40
        Multidimensional Scaling 40
        Cluster Analysis 41
    Rationale for Concept Mapping 44
Data Collection—Phase I 45
    Participants 45
        Characteristics of the Sample 46
        Characteristics of the Abuse Experienced 46
        Healing and Therapy 49
        Summary of Participants 51
    Procedure 52
Data Collection—Phase II 55
    Participants 55
        Question #1: Helpful Impacts 56
        Question #2: Hindering Impacts 57
        Question #3: Helpful Therapy Impacts 58
        Summary of Participants 60
    Procedure 61
Analysis of Data 63
    Multidimensional Scaling 63
    Cluster Analysis 64

Helpful Impacts 65
Hindering Impacts 66
Helpful Therapy Impacts 68
Map Interpretation 70
Conclusion 71

Chapter 4: Results 72
Question #1: Helpful Impacts 72
Description of Clusters 76
Cluster 1: Developing Self-Acceptance and New Skills 76
Cluster 2: Connecting with Others 76
Cluster 3: Having a Strong Support System 76
Cluster 4: Being Validated 77
Cluster 5: Sharing of Self 77
Cluster 6: Stabilizing Self and Establishing Safety 78
Cluster 7: Maintaining Balance and Moving On 79
Overview of Map 80
Question #2: Hindering Impacts 83
Description of Clusters 87
Cluster 1: Unsupportive People 87
Cluster 2: Inadequate Hope and Safety 87
Cluster 3: Isolation and Denial 87
Cluster 4: Experiencing Negative Feelings 88
Cluster 5: Struggling with the Effects 88
Cluster 6: Negative Experiences in Therapy 89
Cluster 7: External Hindrances 90
Cluster 8: Insufficient Insight and Action 90
Overview of Map 91
Question #3: Helpful Therapy Impacts 93
Description of Clusters 97
Cluster 1: Therapist Being Supportive 97
Cluster 2: Experiencing a Positive Therapeutic Relationship 97
Cluster 3: Therapist Availability 98
Cluster 4: Accessing Resources Beyond the Session 98
Cluster 5: Developing New Perspectives and Skills 99
Cluster 6: Redefining of Self 100
Cluster 7: Sharing and Connecting 100
Overview of Map 101
Summary 104

Chapter 5: Discussion 106
Helpful Impacts 106
Relationship with Self 107
Relationships with Others 108
Hindering Impacts 110
Individual-Related Factors 111
Interpersonal Factors 112
External Factors 114
Helpful Therapy Impacts 115
Client-Focused 115
Therapy-Focused 118
Limitations of this Study 120
Implications for Counselling and Healing 121
Recommendations for Future Research 123
Summary 126

References ... 128
Appendix A: Study Description ... 144
Appendix B: Demographic and Information Sheet ... 145
Appendix C: Questionnaire ... 146
Appendix D: Covering Letter for Phase II ... 147
Appendix E: What Do I Do? ... 148
Appendix F: Demographic & Information Sheet ... 149
Appendix G: Checklist of Completed Tasks ... 150
Appendix H: Sorting Instructions for Question #1 ... 151
Appendix I: Rating Instructions for Question #1 ... 152
Appendix J: Statements and Rating Scale for Question #1 ... 153
Appendix K: Instructions for Labelling Process ... 155

List of Tables

Table 1. Number of Offenders 48

Table 2. Relationship of Offenders to Survivors 49

Table 3. Survivors Involvement with Therapy 50

Table 4. Overview of All Participants According to Gender and Age 60

Table 5. Clusters and Items from Survivors' Concept Map of Healing Impacts 74

Table 6. Clusters and Items from Survivors' Concept Map of Hindering Impacts 85

Table 7. Clusters and Items from Survivors' Concept Map of Therapy Impacts 95

List of Figures

Figure 1. Concept map of helpful impacts when healing from CSA 73

Figure 2. Concept map of hindering impacts to healing from CSA 84

Figure 3, Concept map of helpful therapy impacts when healing from CSA 94

Chapter 1: Introduction

The purpose of this research was to develop a conceptual understanding of what adult survivors of childhood sexual abuse perceived as helpful and hindering when healing from abuse. Through open-ended questionnaires and concept mapping, descriptions of men's and women's experiences of what helped and hindered their healing were collected and analyzed. Concept mapping is a process that emphasizes the participants' perspectives, allowing for the study of constructs as experienced by participants, rather than as defined by researchers (Daughtry & Kunkel, 1993; Paulson Truscott & Stuart, 1999; Trochim, 1989b). The results of this study include three pictorial maps representing the participants' experiences of what helped their healing, what hindered their healing, and what in therapy helped their healing.

Definition

The term "childhood sexual abuse" has never been unequivocally defined and in fact, each word contained within the phrase "childhood sexual abuse" has been operationalized in numerous ways (Haugaard, 2000). Often, the definition of "childhood sexual abuse" varies according to what age is used to define "child". In addition, many characteristics that define behaviour as abusive vary on a continuum. For example, a father showering with his two year old daughter is rarely considered abusive or sexual in nature; however, if that same father were to shower with his 14 year old daughter most would assert that it was abusive. The question, "At what point exactly does it change?" illustrates the continuum of grey that is often involved. A similar dilemma in defining sexual abuse is that often behaviour is defined as abusive based on contextual information. For example, a mother rubbing her son's inner thighs on a soccer field after a vigorous game is often construed much differently than a mother rubbing her son's inner thighs in bed at night time. Thus, definitions of childhood sexual abuse vary according to the types of activities considered sexual and the circumstances involved.

At one end of the spectrum, the term "unwanted sexual attention" has been often used to describe the range of behaviours that include non-physical sexualized behaviours such as non-verbal sexual gestures, sexual leers, and sexual name-calling that are unwanted and unsolicited. Whealin (2002) indicated that such behaviours are a common experience for girls, reporting that 98.7% of women in a college sample had experienced such behaviours prior to being 18 years old. Although controversy exists as to whether these behaviours constitute sexual abuse, Whealin proposed that such behaviours should be considered as points along a continuum of sexual abuse and highlighted that unwanted sexual attention has been associated with negative emotional responses for the victims.

In the broadest sense, childhood sexual abuse is defined as sexual activities involving a child and some type of abusive condition (Berliner & Elliott, 2002; Finkelhor, 1994). Abusive conditions indicate a lack of consent and include circumstances such as coercion, a large age difference between participants or a difference in power. A broad definition such as this allows for the inclusion of contact and non-contact incidences as well as intra-familial and extra-familial abuse (Finkelhor, 1994; Maltz, 2003).

Within the research literature, however, a variety of definitions of childhood sexual abuse are implemented. Definitions vary depending on whether non-contact abuse is included (e.g., exhibitionism, pornography, harassment via the phone or internet) or only contact abuse, whether "wanted and unwanted" sexual experiences are included or only "unwanted" ones (e.g., if a 15-year old "consents" to sexual activity with an adult), whether an age difference between the victim and offender is required thereby including or excluding peer sexual abuse, and the age at which the upper limit of the victim is set (Goldman & Padayachi, 2000; Walker, Carey, Mohar, Stein & Seedat, 2004). Some studies only include children under the age of 13 years while others include youth 17 years of age or younger (Holmes & Slap, 1998). Some studies specify that an age difference between the victim and offender, typically of five years or more, must exist. This means that for sexual activity involving a three year old, it would only be defined as abusive if the offender was at least eight years of age or older (Holmes & Slap, 1998).

Such discrepancies in the definition of childhood sexual abuse have complicated the assessment of incidence and prevalence rates and subsequent psychopathology (Walker et al., 2004). These variations in definitions often provide inconsistent findings within the literature. For example, it would not be unreasonable to assume that a study involving both contact and non-contact sexual abuse (e.g., pornography and exhibitionism) would find different prevalence rates and effects than a study that restricted itself to including only more severe abuse that involved multiple incidents and penetration. Differences in definitions of abuse make accurate comparison of the results more difficult across studies.

Prevalence of Childhood Sexual Abuse

Until the late 1970's, childhood sexual abuse was considered to be a rare occurrence (Putnam, 2003). However, the mental health profession has been forced to recognize that the trauma of sexual violence against children is real and not imagined as Freud argued in his Oedipal theory (Bolen, 2001; Greenspan, 1993). There has been a realization that childhood sexual abuse occurs far more frequently than previously thought (Ratican, 1992). Many researchers consider estimates to be conservative due to the difficulties inherent in researching the prevalence of sexual abuse (Draucker, 2000; Finkelhor, Hotaling, Lewis, & Smith, 1990; Goldman & Padayachi, 2000; Ratican, 1992).

As mentioned previously, the variations in how "childhood sexual abuse" is defined within the research literature produces differences in findings. Additional obstacles when assessing the prevalence of childhood sexual abuse include the respondent's cooperation and willingness to disclose information, the reliability of the respondent's memory, and the thoroughness of professionals to document and report abuse (Peters, Wyatt, & Finkelhor, 1986; Walker et al., 2004). Furthermore, because of the secrecy and shame surrounding sexual abuse many cases go unreported (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Finkelhor, 1994). Less than half of the victims of childhood sexual abuse tell anyone about the abuse at the time it occurs (Berliner & Elliott, 2002) and many survivors never disclose. In one study, for example, 33% of women and 42% of men had never disclosed the abuse until asked about it for research purposes (Finkelhor et al., 1990). For these reasons, the actual incidence of childhood sexual abuse is difficult to assess.

Incidence studies examine the number of new cases of sexual abuse occurring or coming to the attention of professionals/authorities in a population during a given time period (Ferguson, 1997). However, these figures are often considered unreliable due to the lack of consistency in definitions of sexual abuse and reporting standards (Berliner & Elliott, 2002). It is estimated that only 6 to 12% of cases are reported to authorities when it occurs (Berliner & Elliott, 2002) and that 40% of cases are never reported to authorities (Finkelhor, 1994). Furthermore, since so much sexual abuse remains undisclosed when it occurs, researchers have often estimated the scope of childhood sexual abuse through prevalence studies based on the retrospective reports of adults in nonclinical settings

(Berliner & Elliott, 2002; Ferguson, 1997). Prevalence rates are usually expressed as a percentage of the adult population that reports having been sexually abused in childhood (Ferguson, 1997).

Estimates of the prevalence of childhood sexual abuse are diverse and confusing, ranging from 2% to 62% for females and 3 to 16% for males (Bolen & Scannapieco, 1999; Finkelhor, 1994). Reliable estimates are difficult to achieve and the variance in reported prevalence rates of childhood sexual abuse is attributed to methodological issues including how sexual abuse is defined, how responses are collected (e.g., face to face interviews, telephone surveys, or mail-in questionnaires), the number and type of questions used to gather information (e.g., one broad question about sexual abuse or numerous specific questions), the sample size and characteristics, the historical timing and potential societal influences, and the definition or age demarcation that defines a child (Beutler, 1993; Bolen, 2001; Bolen & Scannapieco, 1999; Briere & Elliott, 2003; Ferguson, 1997; Goldman & Padayachi, 2000; Holmes, Offen & Waller, 1997; Putnam, 2003; Romano & De Luca, 2001; Walker et al., 2004). Gorey and Leslie (1997) suggest that differences in response rates and definitions of abuse account for half of the variability in prevalence rates. Other researchers point to the significance of the number of screen questions used to elicit disclosures as having the most significant influence on the prevalence rate assessed (Bolen and Scannapieco, 1999; Finkelhor, 1994).

Putnam (2003) described prevalence rates within community samples as typically ranging from 12% to 35% of women and 4% to 9% of men reporting sexual abuse before the age of 18 years. Bolen and Scannapieco (1999) suggest slightly higher rates with 30 to 40 % of female children and 13% or more of male children as having experienced sexual abuse. These are similar to the prevalence rates found by Briere and Elliott (2003) indicating that 32% of women and 14% of men report a history of childhood sexual abuse. Rates suggested by Gorey and Leslie (1997) are considerably lower at 22% for women and 9% for men.

Researchers suggest that prevalence rates for males may be underestimated due to gender specific factors such as boys being less likely to disclose their abuse because of fears of being labelled homosexual, perceptions of desiring the abuse based on physiological responses experienced at the time, and feelings of shame regarding their perceived lack of masculinity (Briere & Elliott, 2003; Etherington, 1995; Finkelhor, 1994; Goldman & Padayachi, 2000; Holmes et al., 1997; Romano & De Luca, 2001; Walker et al., 2004). In addition, it is believed that professionals fail to suspect or inquire about histories of childhood sexual abuse in men (Holmes et. al., 1997; Lab, Feigenbaum, De Silva, 2000). While the previous prevalence rates for boys may be significantly under-estimated, international studies support the universality of higher rates of sexual abuse for girls when compared with boys (Ferguson, 1997; Finkelhor, 1994; Nilsen, 2003; Walker et al., 2004).

Despite the discrepancies in prevalence rates, considerable evidence suggests that a minimum of 20% of women and 5% to 10% of men experience some form of childhood sexual abuse as children (Finkelhor, 1994). In clinical populations, the prevalence rates of a history of childhood sexual abuse are even higher (Lab et. al., 2000). In a study involving inpatients, Wurr and Partridge (1996) reported childhood sexual abuse prevalence rates of 52% for females and 39% of males. Briere, Woo, McRae, Foltz and Sitzman (1997) found that 53% of women presenting in a psychiatric emergency room reported a history of childhood sexual abuse. Other researchers have suggested that among clinical populations the presence of women reporting a history of childhood sexual abuse ranges from 50-70% (Zlotnick, Mattia & Zimmerman, 2001). It has been suggested that therapists can expect that at least one-third, and possibly as much as two-thirds, of their clients will have experienced either physical or sexual abuse or both (Suffridge, 1991). It is important to note that often survivors seek counselling or treatment for issues other than sexual abuse itself and may not volunteer the sexual abuse history without being directly asked (Ratican, 1992). Males are under-represented in psychiatric samples and this may be due to them having been directed to the criminal justice system or substance abuse treatment centres (Putnam, 2003).

In non-clinical samples, up to half of the cases of childhood sexual abuse involve multiple episodes of abuse and in clinical samples this number increases to three-fourths of the cases (Berliner & Elliott, 2002). About one-fourth of the survivors in nonclinical samples describe their abuse as involving attempted or completed penetration (i.e., oral, anal or vaginal) and in clinical samples over half of the cases are reported as involving penetration (Berliner & Elliott, 2002).

In recent studies, suggestions have been made that the prevalence of childhood sexual abuse may be declining (Dunne, Purdie, Cook, Boyle & Najman, 2003; Jones & Finkelhor, 2003; Jones, Finkelhor & Kopiec, 2001; Trocme, Tourigny, Maclaurin & Fallon, 2003). However, research has not yet determined whether the decline is due to a genuine change in the rate of childhood sexual abuse or whether it is a reflection of one or several other causes such as changes in policies, procedures and reporting of abuse (Berliner & Elliott, 2002; Jones & Finkelhor, 2003). In a study that replicated sample characteristics and definitions used a decade earlier, researchers found a consistency in the prevalence rates over the 10 years with two different random samples (Wyatt, 1985; Wyatt, Loeb, Solis, Carmona & Romero, 1999). Although prevalence rates remained relatively unchanged over the ten years, researchers indicated that more women reported only one incident of abuse in the later study but that the incidents of childhood sexual abuse experiences described were significantly more severe (e.g., including attempted oral sex, anal sex, rape, and digital penetration) (Wyatt et al., 1999).

Characteristics of Childhood Sexual Abuse

Childhood sexual abuse is a social problem that crosses socioeconomic, racial and ethnic, age and gender boundaries (Alter-Reid et. al., 1986; Berliner & Elliott, 2002; Bolen, 2001; Briere & Elliott, 2003; Finkelhor, 1994). Examining how each of these characteristics relates to the prevalence of childhood sexual abuse is important to understanding childhood sexual abuse in our society.

Socioeconomic Status (SES)

While more child sexual abuse cases reported to child protection agencies involve children from low socioeconomic classes, community surveys suggest almost no socioeconomic effects (Berliner & Elliott, 2002; Finkelhor, 1994; Putnam, 2003). It is believed that sexual abuse is easier to detect and report when lower SES children are involved (Finkelhor, 1994). In addition, with regard to current family income, in a survey of adult women who experienced sexual abuse in their childhood there was no significant difference in prevalence rates of a history of sexual abuse (Saunders, Kilpatrick, Hanson, Resnic, &Walker, 1999).

Racial/Ethnic

Findings regarding ethnic or racial difference are conflicting, but suggest a few differences across groups. While prevalence rates do not seem to be consistently impacted by race or ethnicity (Saunders et al., 1999), these characteristics may influence how symptoms of childhood sexual abuse are expressed (Berliner & Elliott, 2002; Finkelhor, 1994; Putnam, 2003). For example, Latina girls who experienced abuse involving penetration have been found to be more seriously distressed than African-American or Caucasian girls who experienced penetration as well as than Latina girls who did not experience penetration (Mennen, 1995).

In a study of African American and European American women who experienced childhood sexual abuse, ethnic differences were identified with respect to prevalence, location of abuse and number of incidents of rape. That is, the prevalence rate of childhood sexual abuse was higher for European American women than it was for African American women (Wyatt et al., 1999). In addition, while most women reported that the sexual abuse occurred in the home of the victim and/or perpetrator, European American women reported being abused in public settings (e.g., street, park, neighbourhood, school) significantly more than African American women. Furthermore, European American women were more likely to report incidences of attempted or completed rape (Wyatt et al., 1999). This last finding contradicts earlier research that indicated African American children were more likely than Whites to have experienced vaginal or oral intercourse (Mennen, 1995).

While, some studies suggest that there are racial or ethnic differences regarding the age of onset of abuse and the kind of abuse suffered, other studies indicate that there is not (Mennen, 1995). The issue of how ethnic or racial differences impact prevalence rates and outcomes for survivors of childhood sexual abuse needs ongoing investigations in order to provide clarification.

Age

The average age for the onset of childhood sexual abuse is approximately 9 years old, with a range from infancy to 17 years (Berliner & Elliott, 2002). There has been consistency in the finding that most sexual abuse experiences begin between the ages of 7 and 10 years old (Romano & De Luca, 2001).

Some researchers suggest that boys tend to be older than girls when the sexual abuse first begins (Berliner & Elliott, 2002; Finkelhor, 1994). However, others indicate that there is no difference in age of onset and that results that suggest a difference are distorted by characteristics of the abuse (e.g., shorter duration and extra-familial abuse being more common for boys) and the increased likelihood that older boys do not disclose victimization (Romano & De Luca, 2001).

Gender

Initially, the majority of research regarding the prevalence and effects of childhood sexual abuse was based solely or predominately on females (Holmes & Slap, 1998; Walker et al., 2004). As more research focused on males has been undertaken, some gender differences have emerged. Girls are victimized more often than boys (Finkelhor, 1994), however, a significant portion of sexual abuse victims—approximately 30%--are male (Holmes et al., 1997). Holmes & Slap (1998) concluded that the sexual abuse of boys is "common, under-represented, under-recognized and under-treated" (Holmes & Slap, 1998, p.1860).

Boys are less likely than girls to be abused within the family (Finkelhor, 1994; Holmes & Slapp, 1998; Romano & De Luca, 2001). For girls approximately one-third to one-half of the perpetrators are related to the victim whereas for boys this figure drops to about one-tenth or one-fifth (Berliner and Elliott, 2002; Finkelhor, 1994). On the contrary, boys are more likely to have been abused by offenders who are known to have abused other children (Berliner & Elliott, 2002). Boys are more likely to be abused by females than are girls (Berliner & Elliott, 2002; Finkelhor, 1994). In addition, it is believed that the average duration of abuse is significantly shorter for boys than it is for girls (Romano & De Luca, 2001).

In general, there is a smaller age difference between boys and their offenders than there is between girls and their offenders (Romano & De Luca, 2001). When compared to females, males were more likely to be sexually abused by someone within five years of their own age while females had offenders who were significantly older than themselves (Romano & De Luca, 2001).

Perpetrators

The vast majority of offenders are male (Berliner & Elliott, 2002; Romano & De Luca, 2001). Finkelhor et al. (1990) found that 83% of the offenders against boys and 98% of the offenders against girls were males. Literature regarding female offenders is quite limited, but prevalence rates are thought to range from 1% to 20% of all offenders (Romano & De Luca, 2001). Falling within this range, other researchers have suggested that approximately 5% of offenders are female (Bolen, 2001; Grayston & De Luca, 1999).

It is believed that female offenders are more likely to sexually abuse younger children with whom they have an enduring or familiar relationship (Grayston & De Luca, 1999). Within the literature, there is a pervasive theme that sexual abuse by women is hidden even more deeply than sexual abuse by men given the sexually passive, innocent and nurturing stereotyped perceptions that are often associated with women, especially mothers (Denov, 2003; Grayston & DeLuca, 1999). According to Finkelhor (1994) four types of female offenders have been identified: women who act in conjunction with a male offender, adolescent girls particularly in babysitting positions, lonely and isolated single-parent mothers with small children, and women who develop romantic relationships with adolescent boys.

Typically, an offender is classified by his/her relationship to the victim—family, acquaintance or stranger. It has been suggested that 10% to 30% of offenders are strangers while the remainder are either relatives or acquaintances (Finkelhor, 1994; Saunders et al., 1999). Others suggest that only 5% to 15% of offenders are strangers (Berliner & Elliott, 2002). In addition, estimates suggest that approximately one-third of all offenders are themselves under the age of 18 (Finkelhor, 1994). In community samples, greater than one-third of all childhood sexual abuse cases are believed to involve a relative while 6% to 16% of all cases involve abuse by a parental figure (Berliner & Elliott, 2002). In clinical samples, these figures increase and parental figures account for one-quarter to one-third of offenders while relatives compromise about one-half (Berliner & Elliott, 2002).

Significance of this Research

The sexual abuse of children is a significant social problem that is not bound by gender, age, race or socioeconomic status (Denov, 2003; Paolucci, Genuis & Violato, 2001). A history of childhood sexual abuse has been associated with many negative outcomes (Berliner & Elliott, 2002; Putnam, 2003). As such, research investigating healing from or overcoming childhood sexual abuse is important and necessary.

The three questions guiding this research include “What has contributed to your overcoming the childhood sexual abuse you experienced?”, “What interfered with your healing?” and “What aspects of therapy were helpful in your healing?”. This study is significant in its emphasis on the survivor’s perspective, thereby adding to the small but growing body of knowledge focused on the perceptions and experiences of survivors. By combining the perspectives of individual survivors into a collective voice, this research conceptualizes the survivors’ experiences of what helped and what interfered with healing from childhood sexual abuse. By using a concept mapping approach, this study does not pre-define significant or hindering aspects of healing based on the researchers’ or therapists’ assumptions or beliefs. Rather, it gathers the perspectives and ideas of the participants. In addition, this study is significant in its inclusion of the perspectives of both men and women who have been sexually abused.

Chapter 2: Literature Review

An important step before beginning this research involved examining the existing literature regarding adults who were sexually abused in childhood and their experience of recovery. A brief review of the potential consequences of childhood sexual abuse will be presented including short- and long-term effects, attachment implications, and intervening variables. Then, information regarding overcoming childhood sexual abuse will be reviewed by considering what survivors have experienced as helpful and hindering in their healing in general and, more specifically, helpful in therapy. Finally, the implications of the existing literature will be addressed.

Consequences of Childhood Sexual Abuse

Considerable research has documented the negative consequences of childhood sexual abuse. However, since most studies regarding the effects of such abuse are retrospective in nature, a causal relationship between the sexual abuse and the associated symptoms cannot be assumed (Berliner & Elliott, 2002; Roberts, O'Connor, Dunn, Golding & The ALSPAC Study Team, 2004). A major difficulty in assessing the effects of childhood sexual abuse is that the abuse often occurs within a context of other traumas such as emotional and physical abuse, neglect, and parental alcoholism (Etherington, 1995). Nevertheless, repeated findings have increased confidence in the associations reported and researchers and clinicians have concluded that childhood sexual abuse is a major risk factor for a variety of short-term and long term problems for a significant portion of its victims (Berliner & Elliott, 2002; Briere & Elliott, 1994; Browne & Finkelhor, 1986; Putnam, 2003). While research regarding consequences of childhood sexual abuse has been primarily involved only female survivors, studies involving males show similar consequences (Berliner & Elliott, 2002; Cahill, Llewelyn, & Pearson, 1991; Holmes et al., 1997; Putnam, 2003).

Short Term Effects

In children and adolescents, symptoms associated with childhood sexual abuse include depression, behaviour problems, school difficulties, sleep disturbances, somatic complaints, fearfulness, withdrawal and sexualized behaviour (Briere & Elliott, 1994; Paolucci et al., 2001; Ruggiero, McLeer & Dixon, 2000). In addition, self-perceptions of helplessness and hopelessness, impaired trust, self-blame and low self-esteem have been documented in child victims and are believed to often continue through adolescence and adulthood (Briere & Elliott, 1994; Ruggiero, McLeer & Dixon, 2000). Post-traumatic stress disorder symptoms (PTSD) such as fear, anxiety and concentration problems are exhibited more often by children who have been sexually abused than by their non-abused peers (Briere & Elliott, 1994). When sexually abused children are compared to their non-abused peers, they tend to be less socially competent, more aggressive, and more socially withdrawn (Briere & Elliott, 1994; Paolucci et al., 2001). As well, sexually abused children tend to be less trusting and perceive themselves as different. They have fewer friends in childhood, less satisfaction in relationships, and report less closeness with their parents than do non-victims (Briere & Elliott, 1994).

Most of the symptoms associated with childhood sexual abuse victims are present in clinical samples in general and cannot be assumed to be related to a history of childhood sexual abuse. However, one exception to this is that sexualized behaviour seems to be more significantly associated with childhood sexual abuse victims that with non-abused clinical youth (Beitchman, Zucker, Hood, DaCosta & Akman, 1991). That is, victims of childhood sexual abused are more likely than non-victims to develop some type of inappropriate sexual or sexualized behaviour (Beitchman et al., 1991; Briere & Elliott, 1994). For example, children may have an increased interest in sexuality and engage in sexual play, masturbation, seductive or sexually aggressive behaviour and display age inappropriate sexual knowledge (Berliner & Elliott, 2002). For adolescents this sexualized behaviour may get expressed as sexual acting out such as promiscuity and possibly a higher rate of homosexual contact (Beitchman et al., 1991; Paolucci et al., 2001). Childhood sexual abuse is also associated with teenage pregnancy and relationship difficulties (Putnam, 2003).

Many children and adolescents engage in avoidant behaviours in an effort to cope with the trauma of having been sexually abused. These coping or avoidance behaviours include activities such as dissociation, substance abuse, suicidality and other tension-reducing activities (e.g., bingeing and purging, self-mutilation, indiscriminate sexual behaviour) (Briere & Elliott, 1994; Paolucci et al., 2001). Frequently these avoidance behaviours and self-destructive methods of coping begin in childhood or adolescence and continue into adulthood, resulting in increased symptoms, lower self-esteem and stronger feelings of anger and guilt (Briere & Elliott, 1994; Paolucci et al., 2001).

Long Term Effects

There is a direct association between a history of childhood sexual abuse and an increased risk for adverse outcomes (Nelson, Heath, Madden, Cooper, Dinwiddie et al., 2002). It has been associated with numerous long-term effects including low self-esteem, depression, feelings of isolation and stigma, anxiety, anger, aggression, hostility, fear, self-injurious or self-destructive behaviours, feelings of guilt or self-blame, interpersonal dysfunction, eating disorders, sexual dysfunction; sexually inappropriate behaviours, sleep disturbances, suicidality, obsessive compulsive behaviours, antisocial behaviours, difficulty parenting, difficulty trusting others, a tendency toward re-victimization, and difficulty establishing and maintaining relationships (Alter-Reid et al., 1986; Banyard, Williams & Siegel, 2001; Beitchman et al., 1992; Blume, 1990; Briere & Elliott, 2003; Browne & Finkelhor, 1986; Cahill et al., 1991; Dinwiddie et al., 2000; Kessler & Bieschke, 1999; Koss et al., 2003; Lisak, 1994; Paivio & McCulloch, 2004; MacMillan et al., 2001; Putnam, 2003; Romano & De Luca, 2001; Sanderson, 1995).

Overall, females who have been sexually abused are more likely to display internalizing behaviours (e.g., depression, anxiety, PTSD, suicidal ideation) whereas males are more likely to manifest externalizing behaviours (e.g., oppositional behaviours, aggression, impulsivity, and substance abuse) (Dinwiddie et al., 2000; Feiring, Taska & Lewis, 1999; Finkelhor, 1994; Holmes & Slap, 1998; Romano & De Luca, 2001; Walker et. al., 2004; Weiss, Longhurst & Mazure, 1999). In general, female survivors report increased sexual anxiety while males report more eroticism (Feiring et al., 1999; Maltz, 2003). Women who experienced abuse that was considered more severe reported more use of both avoidant coping strategies (sexual avoidance and problems) and self-destructive coping strategies than women who experienced less severe forms of abuse (Merrill, Guimond, Thomsen & Milner, 2003). Similarly, for males, one study indicated that childhood sexual abuse is associated with later problems only when contact forms of sexual abuse are considered (Collings, 1994). However, Noll, Trickett and Putnam (2003) caution that no sexual abuse should be considered "mild" since sexual distortion (i.e., preoccupation, aversion or ambivalence) was associated with a history of childhood sexual abuser regardless of the characteristics of the abuse itself.

Men who were sexually abused in childhood are more likely than women to express some sexual interest in children (Beitchman et al., 1992; Finkelhor, 1994). However, research also suggests that sex offenders who experienced childhood sexual abuse also experienced other forms of family pathology and violence when growing up (Romano & De Luca, 2001). In a qualitative study involving 25 adult male survivors, reports of sexual problems were prominent and manifested as dissatisfaction and anti-social sexual and aggressive activity (Etherington, 1995). Men with a sexual abuse history involving one or more male offenders reported greater confusion regarding gender and sexual orientation than did men abused solely by female offenders and females who were sexually abused (Etherington, 1995; Lisak, 1994; Mendel, 1995).

Childhood sexual abuse is considered a powerful predictor of later psychiatric symptoms and disorders (Briere et al., 1997; Walker et al., 2004). Psychiatric conditions such as mood disorders, borderline personality disorder, somatization disorder, substance abuse disorders, posttraumatic stress disorder and other anxiety disorders, dissociative identity disorder, and bulimia nervosa have been clinically associated with childhood sexual abuse (Lombardo & Pohl, 1997; MacMillan et al., 2001; Mueser et al., 1998; Putnam, 2003; Romano & De Luca, 2001; Taylor & Jason, 2002; Weiss et al., 1999; Wurr & Partrige, 1996).

One of the most common long-term effects of childhood sexual abuse, particularly for women, is depression (Weiss et al., 1999). Adult women who had been raped in childhood were twice as likely as nonvictims of rape to have experienced a major depressive episode and three times as likely to be currently depressed (Saunders et al., 1999). Among individuals with major depression, survivors of childhood sexual abuse may be at a higher risk for additional psychiatric conditions (e.g., particularly PTSD and BPD) and for episodes of depression that are prolonged in nature (Zlotnic, Mattia & Zimmerman, 2001). Other researchers suggest that co-morbid Axis II diagnoses of dependent, avoidant and anti-social personality disorders are also common (Owens & Chard, 2003). The association between a history of childhood maltreatment and psychiatric illnesses exists for both genders but tends to be stronger for women than men (MacMillan et al., 2001).

Zanarini et al. (2002) found that the majority of borderline patients with a history of childhood sexual abuse describe abuse characterized as severe in nature. More specifically, abuse is described as occurring in childhood and adolescence, at least once a week, for a minimum of a year, by a parent or well known person, and by two or more offenders. In addition, over 50% of the survivors indicated that their abuse involved penetration and the use of force or violence. The researchers also found that the severity of abuse was related to the severity of borderline-type symptoms such as impairments in affect, cognition, impulsivity and disturbed interpersonal relationships (Zanarini et al., 2002). In a different study, Heffernan and Cloitre (2000) found that the diagnosis of BPD was associated with an earlier age of onset of childhood sexual abuse as well as with significantly higher rates of maternal physical and verbal abuse. It is clear that women who have been sexually abused in childhood are at a substantially increased risk to develop a wide range of psychopathology (Kendler et al., 2000).

Recent research has linked a history of childhood sexual abuse with various chronic fatigue illnesses (i.e., idiopathic chronic fatigue, chronic fatigue explained by a psychiatric condition and chronic fatigue explained by a medical condition) although found that childhood sexual abuse was not a significant predictor of chronic fatigue syndrome itself (Taylor & Jason, 2002). Nonetheless, childhood sexual abuse was the only significant predictor of fatigue outcomes when considering additional influences such as childhood death threat, total number of child abuse events and lifetime abuse events (Taylor & Jason, 2002).

While the link between childhood trauma and adult psychopathology is well established, the exact nature of the relationship is not yet fully understood. Several studies have associated childhood sexual abuse with dissociative symptoms (Briere & Elliott, 1994). However, Mulder, Beautrais, Joyce and Fergusson (1998) hypothesize that such findings are biased by over-reliance on clinical samples and by the interference of other mediating factors (e.g., physical abuse and psychiatric illnesses). In their large (n=1028) random sample of a non-clinical population the effects of childhood sexual abuse on dissociation were not direct, but rather they were due to the association of the abuse with current psychiatric disorders and with childhood physical abuse (Mulder et al., 1998).

Survivors of childhood sexual abuse experience relationship difficulties and parenting problems (Davis & Petretic-Jackson, 2000; Roberts et al., 2004). As adults, survivors are more likely to be living in a non-traditional family (e.g., single parent or step-family) (Roberts et al., 2004). Female victims of childhood rape were nearly twice as likely to be divorced as nonvictims (Saunders et al., 1999). They are more likely to remain single and, when they do marry, they are more likely to divorce or separate than their non-abused peers (Berliner & Elliott, 2002; Briere & Elliott, 1994). Typically, survivors report having fewer friends, less interpersonal trust, less satisfaction in their relationships, more maladaptive interpersonal patterns, and greater discomfort, isolation and interpersonal sensitivity (Briere & Elliott, 1994). When combined with dissatisfaction in a survivor's marital relationship, a history of childhood sexual abuse is predictive of parent-child role-reversals involving a mother's emotional over-dependence upon her child (Alexander, Teti & Anderson, 2000).

Attachment and Sexual Abuse

The long-term effects of childhood sexual abuse, particularly incest, include psychiatric disorders that reflect impairments in self and social functioning (Cole & Putnam, 1992). That is, two areas of a person's life that seem to be particularly impacted are relationship with self and relationship with others. "Sexual abuse has the power to fundamentally damage a victim's relationship both to themselves and to other people" (Lisak, 1994, p.544). Interpersonal difficulties are common among survivors of childhood sexual abuse (Briere & Elliott, 1994). Some understanding of why being sexually abused in childhood causes difficulties in subsequent relationships can be understood by briefly considering the literature on attachment.

Attachment is an ongoing, reciprocal relationship that profoundly influences every aspect of human life. It involves a deep and enduring connection established between a child and caregiver (Levy & Orlans, 1998). Bowlby (1988) described attachment as a biologically based bond with a caregiver that serves a protective function and regulates distress. As such, attachment behaviours are triggered by threats to a child's health or survival such as hunger, illness, tiredness or perceived external dangers in the environment. When triggered, infants behave in ways that maintain or enhance their connection to caregivers in order to receive their care, nurturance and protection. When no danger is present, the mother or caregiver becomes a secure base (Goldberg, 2000).

According to attachment theory, infants and young children develop expectations and internal working models about the role of self and others in relationships based on early experiences with caregivers or attachment figures (Alexander, 1992). Attachment patterns in childhood have broadly been characterized as secure or insecure. More specifically, insecure attachments have been identified as anxious-avoidant and anxious-resistant (or ambivalent) (Goldberg, 2000; Peluso, Peluso, White & Kern, 2004).

In terms of infants, those with secure attachments actively seek comfort and use the attachment figure as a secure base from which to venture and explore, returning for comfort and security as needed. Those infants with anxious-avoidant attachments seem unconcerned about whether the mother was present or absent and diverted attention from the attachment figure, seemingly to avoid anxiety associated with potential rejection. Infants categorized as anxious-resistant appear preoccupied with getting maternal attention and contact thereby appearing extremely dependent and excluding other activities (Alexander, 1992; Goldberg, 2000; Peluso et al., 2004). More recently, an additional classification—a disorganized attachment style—has been described as a mixture of the anxious-avoidant and anxious-resistant styles (Peluso et al., 2004) and is considered a very insecure pattern often linked to infants who have been maltreated infants or who have a mother who is depressed (Goldberg, 2000). According to Stosny (1995):

> The primary builder of an individual's sense of self, attachment relationships can also serve as the principal self-destroyer, for abuse from no other source can reach so deeply into the structure of self. The very qualities we cherish in attachment relationships create an unparalleled emotional vulnerability to attachment figures (p. 3).

The primary attachment relationships become internalized and defined as expectations of self and others. Through attachment figures, individuals develop a sense of self, including a sense of whether one is worthy of love and whether one's love is worthy of others. By being connected to other people through attachment, individuals can see themselves and learn of their importance, value, acceptability, and worth (Levy &

5

Orlans, 1998). Regardless of the nature of the environment in which a child lives, each child is believed to form some sort of attachment in order to survive. If caregivers are consistent and responsive, then positive expectations or models develop and secure attachments are formed, enabling the child to enter adulthood with a healthy capacity for intimacy. However, when caregivers' responses are inconsistent or inadequate, negative models and insecure attachments develop. As a result, the self is viewed as undeserving of comfort and love and/or others are viewed as essentially unreliable, disappointing, untrustworthy and uncaring (Alexander, 1992; Swanson & Mallinckrodt, 2001).

Attachments, whether secure or insecure, are considered adaptive behaviours at the time they are formed based on interactions with the primary caregiver (Peluso et al., 2004). As the primary attachment relationships become internalized, the expectations of self, others and relationships form and influence subsequent interactions with the environment and other social relationships (Peluso et al., 2004). Attachment styles or internal working models developed in childhood are believed to be relatively stable over time, shaping a person's behaviour and affect into adulthood. In a 20 year longitudinal study, individual differences in attachment security were found to be stable across significant portions of the lifespan (Waters, Merrick, Treboux, Crowell & Albersheim, 2000). In addition, negative life events were found to play a role in causing changes from a secure attachment style to an insecure one (Waters et al., 2000).

Insecure attachment styles that form in childhood can become problematic as the child becomes older and attempts to form new relationships (Peluso et al., 2004). In adult life, a healthy and secure attachment style involves valuing both autonomy of self and intimacy or closeness in relationships (Waldinger et al., 2003). Unhealthy or pathological attachment, on the other hand, is characterized by terms like interpersonal dependency, avoidance of intimacy, fear of abandonment, and jealousy (Stosny, 1995). Insecurely attached individuals tend to over-value closeness at the expense of autonomy or overvalue autonomy at the expense of closeness (Waldinger et al., 2003).

Alexander (1992) applied attachment theory to childhood sexual abuse and proposed that the various subtypes of insecure attachments are linked to different adverse reactions when childhood sexual abuse is experienced. For example, it was suggested that resistant attachment patterns in childhood predisposes the adult survivor to re-victimization, difficulties with interpersonal relationships, hypervigilance, symptoms of anxiety and fear, and borderline personality disorder. Having an avoidant attachment style was believed to be more associated with a sense of social isolation and estrangement from others as well as with denial-based coping strategies, avoidance of memories of the abuse, and a decreased ability to express emotion and intimacy with others. Finally, disorganized attachment, on the other hand, was proposed to be associated with dissociative coping strategies, an increased likelihood of post-traumatic stress disorder symptoms, borderline personality disorder and multiple personality disorder.

In addition to suggesting that certain long-term consequences of childhood sexual abuse were associated with probable attachment styles, Alexander (1992) also noted that several themes associated with insecure parent-child attachment styles are often present in families characterized by sexual abuse (e.g., rejection, role reversal/parentification, and fear/unresolved trauma). Subsequent research involving incest survivors has indicated that insecure attachments among incest survivors are common and that such attachments are associated with characteristics of personality disorders and future distress and depression (Alexander et al., 1998).

While primary attachments are formed between a child and a caregiver, it has often been noted that a secure attachment style can change to an insecure one as a result of negative life experiences (Bolen, 2002; Waters et al., 2000). Childhood sexual abuse, one type of negative life experience, usually occurs within an existing relationship and is non-consensual and developmentally inappropriate (Berliner & Elliott, 2002; Briere & Elliott, 1994). As such, sexual abuse alters the relationship in which it occurs and interferes with normal developmental processes, thereby increasing the risk of maladjustment in adulthood (Berliner & Elliott, 2002; Levy & Orlans, 1998). Sexual abuse can disrupt the processes of learning to trust, act autonomously, and form stable, secure relationships (Berliner & Elliott, 2002).

Intervening Variables

While the sequalae following childhood sexual abuse is well-documented, sexual abuse does not always produce negative effects and not all effects are major (Briere & Elliott, 2003; Davis & Petretic-Jackson, 2000). For example, not all children have serious psychiatric symptoms following sexual abuse. Up to 40% of children do not show signs of abuse related problems (Berliner & Elliott, 2002; Putnam 2003); similarly, some adult survivors report few or no effects (Berliner & Elliott, 2002). Wyatt et al. (1999) reported that two-thirds of women who experienced childhood sexual abuse involving contact indicated that they had no long term effects. Admittedly, this does not necessarily mean there were no effects; however, this finding supports the notion that many survivors do not suffer major long-term consequences. In one study, researchers reported that 42% of adult survivors believed they had not been affected at all by the sexual abuse (Baker & Duncan, 1985). In another study, Herman, Russell and Trocki (1986) concluded that approximately 22% of survivors felt there were no long-lasting effects and 27% described only slight residual effects.

On the other hand, some survivors experience serious impairments in numerous areas of their life (Berliner & Elliott, 2002). The degree of distress or symptomology experienced by a survivor of childhood sexual abuse seems to be influenced by abuse specific variables, individual or child-related factors, and environmental influences (Briere & Elliott, 1994).

Abuse Specific Variables. Aspects of abuse that may suggest a worse prognosis include genital contact (especially acts involving oral/anal/vaginal penetration), an increased frequency of abuse, knowing the perpetrator (particularly having a father or father-figure be the perpetrator), having multiple abusers, the use of force or threat of force and incidents perceived as especially upsetting at the time (Beitchman et al., 1991; Beitchman et al., 1992; Briere & Elliott, 2003; Browne & Finkelhor, 1986; Kessler & Bieschke, 1999; Koss et al., 2003; Roberts et al., 2004; Ruggiero, McLeer & Dixon, 2000; Walker et al., 2004; Wurr & Partridge, 1996).

One study examining various aspects of childhood sexual abuse with later development of psychopathology found that, as an independent characteristic, incestuous abuse was not more related to later problems than non-incestuous abuse. However, usually incestuous abuse was more severe, started at a younger age, was more difficult to disclose and was associated with a more negative family of origin histories. In these respects, duration and severity of the abuse were more important predictors than the relationship to the offender (Lange et al., 1999).

Some researchers contend that when sexual abuse occurs at multiple points in the lifecycle, survivors experience higher levels of mental health symptoms than when the abuse occurs at only one point in time (Banyard, Williams & Siegel, 2001). The subsequent onset of depression in survivors of childhood sexual abuse appears to be particularly correlated with the severity of sexual abuse experienced, especially for women (Weiss et al., 1999). Children who have a close relationship with their offender (e.g., as is the case in intra-familial abuse) may experience more negative consequences (Romano & De Luca, 2001). Mendel (1995) suggested that sexual abuse involving a relative was one of the most powerful predictors of psychological distress. Other researchers conclude that type of abuse, relationship to perpetrator, and number of incidents of abuse did not influence the outcomes that survivors experienced when sexually abused (Paolucci et al., 2001).

Child-Related Variables. Child-related factors believed to mediate the impact that childhood sexual abuse has on a given individual include variables such as temperament, coping style, resiliency, developmental history, prior psychological functioning and attribution style (Briere & Elliott, 2003; Koss et al., 2003; Oaksford & Frude, 2003; Putnam, 2003; Runtz & Schallow, 1997). Di Palma (1994) highlights how a severe sexual abuse history does not ensure a negative outcome and hypothesized that coping strategies used may facilitate healthy adjustment. Paolucci et al. (2001) concluded that gender, SES, and age when abused did not influence the outcomes that survivors experienced when sexually abused.

Some researchers propose that the impact of sexual abuse will vary according to age-related variables including the age at first abuse and the number of developmental transitions that occur while the abuse persists (Cole & Putnam, 1992). However, findings regarding the child's age at the time the sexual abuse began (i.e., age of onset) have been contradictory with some research indicating a worse prognosis with early onset (Browne & Finkelhor, 1986; Mendel, 1995; Romano & De Luca, 2001) while other studies point to an older onset corresponding with more severe symptoms (Briere & Elliott, 2003; Ruggiero et al., 2000).

A victim's age at the time of disclosure of the sexual abuse has been found to effect the manifestation of symptoms, with adolescents showing more pervasive psychological distress than children (Feiring, Taska & Lewis, 1999). Adolescents had higher levels of depressive symptoms, greater negative reactions by others, lower self-worth and less social support than children (Feiring et al., 1999).

Environmental Variables. Environmental risk factors for childhood sexual abuse include family characteristics such as having fighting or conflict, absence of one or both parents, presence of a step-parent, parental substance abuse, parental psychopathology, and physical abuse and neglect (Berliner & Elliott, 2002; Nelson et al., 2002; Walker et al., 2004). Furthermore, survivors of childhood sexual abuse report more exposure to a wide variety of traumas than do their non-abused peers (Banyard et al., 2001).

The families of children who have been sexually abused are described as less cohesive, more disorganized and generally more dysfunctional than the families of non-abused children (Berliner & Elliott, 2002). Childhood sexual abuse frequently occurs with other adverse childhood experiences such as emotional abuse, physical abuse, neglect, having a battered mother, parental separation or divorce, parental substance abuse, and mental illness or criminal behaviour within the household (Dong, Anda, Dube, Giles & Felitti, 2003). Abusive and/or rejecting parenting was identified as predictive of both contact and non-contact sexual abuse in the lives of males (Collings, 1994). Marital discord, family violence and single-parent families were more common for survivors of childhood sexual abuse than for non-abused control groups (Beitchman et. al., 1992). The atmosphere in the family of origin substantially impacts subsequent psychopathology (Lange et al., 1999). Having an appropriate support system is identified as an important mitigating factor (Roberts et al., 2004). In addition, how others respond to the disclosure may influence a person's response to being sexually abused (Briere & Elliott, 2003; Lange et al., 1999; Putnam, 2003; Roberts et al., 2004). Social support appears to be an important factor that influences how childhood sexual abuse impacts children and adult survivors (Runtz & Schallow, 1997).

Summary

The relationship between childhood sexual abuse and its effects is complicated. As Mullen (1993) stated, "Abuse is not destiny, but it does make progress toward successful social, interpersonal, and intrapsychic functioning in adult life more difficult" (p. 431). While some survivors report few or no negative impacts, others experience serious impairments in numerous areas of their life (Berliner & Elliott, 2002; Runtz & Schallow, 1997; Valentine & Feinauer, 1993). Very little is known about survivors who are functioning at higher levels (Davis & Petretic-Jackson, 2000). Although the long-term effects are not inevitable, the risk of mental health impairment for victims of child sexual abuse should be taken very seriously (Browne & Finkelhor, 1986; Cahill et al., 1991).

Overcoming Childhood Sexual Abuse

Considerable research has been done on the incidence and prevalence of sexual abuse, how it has affected those who have experienced it, and how mental health professionals believe affected people should be treated (Nelson-Gardell, 2001). Traditionally, much of the information available about what helps survivors of childhood sexual abuse heal has been based on the clinical impressions of individual therapists (Bass & Davis, 1988, 1994; Beutler & Hill, 1992; Courtois, 1988; Dolan, 1991; Engel, 1989; Glaister & Abel, 2001; Hill & Alexander, 1993; Nelson-Gardell, 2001). The vast majority of research regarding treating sexual abuse survivors is based on therapists' views of what is helpful; however, researchers have found that client and therapist perceptions about experiences in therapy frequently differ (Beutler et al., 2004; Bonney, Randall & Cleveland, 1986; Caskey, Barker & Elliott, 1984; Dill-Standiford, Stiles & Rorer, 1988; Elliott & James, 1989; Fuller & Hill, 1985; Hill & Alexander, 1993; Hill & Lambert, 2004; Hill, Mahalik & Thompson, 1989; Orlinsky, Ronnestad & Willutzki, 2004; Thompson & Hill, 1991).

Regardless of the presenting issue, the client's perception of therapy experiences has been gaining more attention and recognition in recent years (Bowman & Fine, 2000; Palmer, Stalker, Gadbois & Harper, 2004). However, individuals who were sexually abused in childhood have been given little opportunity to describe healing from their own perspectives (Glaister & Abel, 2001; Nelson-Gardell, 2001).

Given that childhood sexual abuse is "a societal tragedy of epidemic proportions" (Bolen, 2001, p.181), developing an understanding of what is helpful in overcoming childhood sexual abuse is imperative. Since many survivors of childhood sexual abuse have no or few negative after effects (Briere & Elliott, 2003; Davis & Petretic-Jackson, 2000), it is important to know what influences healing both within therapy and outside of therapy. In order to gain an understanding of healing from childhood sexual abuse, research related to survivors' perceptions of helpful and hindering impacts on healing will be reviewed. Then, helpful impacts specifically related to therapy will be considered in more detail. Since the literature regarding survivors' experience in therapy is somewhat minimal (Glaister & Abel, 2001; Hill & Alexander, 1993), studies about helpful and hindering impacts for clients with other presenting issues will also be considered.

Helpful Impacts

In a naturalistic study, Glaister and Abel (2001) explored helpful aspects of healing from the perspective of 14 female survivors of childhood sexual abuse who believed they had achieved some degree of healing. From the perspectives of the survivors, several factors facilitated healing: getting information about abuse, having supportive relationships, participating in experiential activities, having inner-strength and beliefs, making and being committed to the decision to heal, learning new skills and ways of thinking, and, coming to terms with what happened (Glaister & Abel, 2001). However, the survivors described being helped most of all "by believing that healing was possible" (Glaister & Abel, 2001, p. 194).

Godbey and Hutchinson (1996) used a qualitative approach to explore ten female incest survivors' descriptions of helpful factors. Factors identified as helpful included having a therapist they could trust, having emotionally supportive family and friends, and being committed to healing (Godbey & Hutchinson, 1996). Other features that facilitated their healing included achieving some stability (e.g., no acute depression or active alcohol/drug use), working through feelings (e.g., grief, abandonment, betrayal, anger, loss of control), developing insight and being willing to change, experimenting with new behaviours, assigning responsibility solely to the abuser, finding joy in life, and accepting the abuse as part of one's past (Godbey & Hutchinson, 1996).

Malmo and Laidlaw (1995) examined the strategies used outside of therapy to facilitate healing survivors of childhood sexual abuse. All of the participants, 140 females and three males, were attending therapy and were identified by their therapist as individuals who engaged in activities between therapy sessions to facilitate their healing. Through this study, 18 categories of healing strategies were identified: writing, using resource materials, using therapeutic strategies (e.g., relaxation or grounding skills), engaging in artistic expression, talking about the abuse, engaging in physical activities, engaging in self-care, participating in spiritual activities, reaching out to personal resources, getting massages or other body work, listening to music, and attending therapy groups, gaining education, taking action, working, participating in leisure activities, accessing external resources and taking medication (Malmo & Laidlaw, 1995, 1996). Participants described these healing strategies as facilitating healing outside of but concurrent to therapy sessions.

Valentine and Feinauer (1993) investigated what 22 female survivors of childhood sexual abuse perceived as helpful in overcoming childhood abuse. Notably, the women in this study considered themselves to be "functioning well", they were either employed or not in need of financial assistance and had no history of institutionalization (i.e., hospitals, prisons, shelters). The helpful factors identified by survivors in this study included being able to find emotional support outside the family, believing in themselves (i.e., self-regard), having religion or spirituality (i.e., seen to increase support networks, help make meaning, free them from blame/guilt, and believe in their worth/value), making external attributions and putting the abuse in perspective (e.g., recognizing it was not their fault and believing in a future that would be abuse free), having an internal locus of control and sense of personal power, and having an optimistic and positive philosophy of life (Valentine & Feinauer, 1993).

Feinauer (1989) highlighted the importance of survivors having a strong, healthy support system that included relationships in which they were able to express their emotions. Fifty-seven female survivors of childhood sexual abuse participated in this study that examined the relationship of treatment to adjustment. Of these women, 36 had attended therapy and 21 had not. Adjustment to the childhood abuse was positively impacted when the women were able to establish or have access to an effective support network. The quality of the support system was seen as vital since the women needed to be able to express themselves and confide in someone in order to adjust to their trauma. Sometimes this support system involved therapists, but other times it was limited to family members, friends, and or spouses.

Hindering Impacts

There is little information available regarding survivors' perspectives of what interferes with healing from childhood sexual abuse and most existing literature focuses specifically on hindering experiences that occur within a therapeutic context. In a qualitative study involving 14 female survivors of childhood sexual abuse who believed they had achieved some degree of healing, Glaister and Abel (2001) investigated hindering impacts that occurred both within and outside of therapy. The survivors in this study identified several obstacles to healing that occurred both within and outside of therapy: relationships with people who did not listen or understand, growth or empowerment not being encouraged, therapists and others who lacked training or had not worked on their own healing, survivors not receiving information essential for healing, contextual issues not being addressed and the survivors' own negative beliefs, feelings and behaviours (Glaister & Abel, 2001).

Specifically related to hindering impacts within a therapeutic context, Armsworth (1989) examined clients' perspectives of hindering events in therapy for 30 female survivors of childhood incest. Four practices or conditions were identified by the participants as least helpful or even harmful: (1) lack of validation of the client's experience; (2) blaming the victim; (3) negative, rejecting or absent responses from the therapist; and (4) exploitation or victimization of the client (Armsworth, 1989).

In one of the few studies focused exclusively on the perceptions of men, Draucker and Petrovic (1997) interviewed 19 male survivors of childhood sexual abuse who described negative therapy incidents or impacts. Negative experiences identified included therapists crossing sexual boundaries (e.g., either propositioning clients or having sex with them), therapists suggesting that they believed clients were sexually attracted to them [the therapist], therapists abruptly terminating therapy for financial reasons, therapists being judgmental and stereotyping minorities, therapists having a rejecting response to clients' disclosures, therapists lacking training and experience (i.e., inexperienced, uninformed about abuse issues, or unskilled), therapists who exclusively controlled the process, therapists who were silent and withholding, therapists with obvious gender biases (e.g., female therapists with unresolved issues with men), and therapists who struggled to let the clients move on when it was time for therapy to end (Draucker & Petrovic, 1997). The researchers concluded that incidents that "leave male survivors feeling abandoned, misunderstood, controlled, or violated have long-lasting destructive consequences" (Draucker & Petrovic, 1997, p. 153).

Other hindering impacts that have been described by survivors relate to situations experienced in group treatment settings. For example, two to seven years after completing an analytic group, female survivors of childhood sexual abuse identified negative aspects of the group as including reliving of painful experiences, having a male therapist present, and feeling threatened by some of the other group members (Hall & King, 1997). Similarly, in a qualitative study exploring aspects of an inpatient treatment program, survivors of childhood abuse identified unhelpful aspects as including being upset by process groups (e.g., overwhelmed by other stories), having difficulty accessing staff, having medication or other natural remedies controlled, and having difficulty at discharge (Palmer et al, 2004). Difficulties at discharge included perceiving a lack of follow-up from the program, being left feeling vulnerable and open, and returning to an unchanged world (Palmer et al., 2004). Although some of these factors are fairly specific to group or inpatient programs (e.g., upset by process groups or having medications controlled), insight into potentially hindering aspects to healing for survivors of childhood sexual abuse can be gained. For example, inferring from results of these studies, it would seem that hindering factors to healing from childhood sexual abuse might include limited accessibility to professionals, inaccessibility of resources, emotional vulnerability, and lack of support outside of or after therapy ends.

Although not related directly to survivors of childhood sexual abuse, a few studies have explored unhelpful aspects of therapy in general. Since the research regarding hindering impacts from the perspectives of survivors of childhood sexual abuse is limited and given that many adult survivors attend therapy, it seems relevant to explore what clients in general have found unhelpful or hindering within a therapeutic setting.

An early study regarding non-helpful events in counselling identified events such as misperception, negative counsellor reaction, unwanted responsibility, repetition, misdirection, and unwanted thoughts as unhelpful or hindering (Elliott, 1985). A study by Llewelyn, Elliott, Shapiro, Hardy and Firth-Cozens (1988) found similar results and suggested that the most common hindering impact for clients was having unwanted thoughts which were seen to include unwanted responsibility, misperception, negative therapist reaction, misdirection, and repetition. In another study, results of post-session evaluations indicated that missed opportunities and brief difficult moments in an overall positive session were perceived as hindering the counselling process (Lietaer, 1992).

More recently, Paulson, Everall and Stuart (2001) used a concept mapping approach to examine clients' perceptions of experiences that interfered in the counselling process. Three core aspects of counselling were identified by clients as hindering: (1) *Counsellor Behaviours* which included a lack of connection, negative counsellor behaviours, insufficient counsellor directiveness, and lack of responsiveness (2) *External and Structural Barriers*, that is, the structure of counselling and barriers to feeling understood, and (3) *Client Variables* such as concerns about vulnerability, lack of commitment and motivation, and uncertain expectations (Paulson et al., 2001).

In a qualitative study investigating the hindering impacts in therapy as experienced by clients in couple's counselling, unhelpful aspects identified included the unequal treatment of partners, the therapist talking when the client wants to talk, the connotation of the term "therapy", the one-hour session being too brief, and the lack of a bridge between therapy and day-to-day life (Bowman & Fine, 2000). While the issue of unequal treatment of partners is specifically related to couple therapy, some of the other issues could potentially be experienced as unhelpful by clients in individual therapy and therefore are important to note as having been previously identified as hindering to the therapy process.

Helpful Therapy Impacts

Survivors of sexual abuse present in therapy with a wide variety of symptoms and they have significantly higher service costs than individuals with no history of abuse (Newman, Greenly, Sweeney & Van Dien, 1998). It is likely that every mental health clinician will—whether they know it or not—work with adult survivors of sexual abuse at some time (Feinauer, 1989; Suffridge, 1991).

A substantial body of evidence exists indicating that psychotherapy is effective (Elkin et al., 1989; Elkin, 1994; Elliott & Shapiro, 1988; Lambert & Cattani-Thompson, 1996; Lambert & Ogles, 2004; Lambert, Garfield & Bergin, 2004; Wampold, 2001). Not only is therapy effective and beneficial, but it has also been shown to produce outcomes that are both statistically and clinically significant (Lambert & Ogles, 2004; Lambert et al., 2004). However, researchers have also suggested there is relatively little difference in outcomes secured when different forms of psychotherapy have been compared (Elkin et al., 1989; Garfield, 1990; Gelso & Carter, 1985, 1994; Greenberg, 1986; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Lambert et al., 2004; Lambert & Ogles, 2004; Lambert, Shapiro & Bergin, 1986; Miller, Hubble & Duncan, 1995; Strupp, 1982; Walborn, 1996; Wampold, 2001). That is, although psychotherapy produces change, it is not always clear what contributes to an effective therapeutic experience (Lambert et al., 2004).

Existing literature regarding the client's perspective of helpful aspects of therapy will be examined by first considering the literature related specifically to survivors of childhood sexual abuse who have attended individual therapy. Then, information regarding survivors' perceptions of helpful impacts in group therapy will be reviewed. Finally, helpful events in therapy from the perspective of clients with a variety of presenting issues will be discussed.

Some of the literature regarding survivors' perceptions of helpful impacts to healing described factors that were potentially experienced both within and outside of therapy. For example, getting information about abuse, having supportive relationships and participating in experiential activities (Glaister & Abel, 2001) were all described by survivors of sexual abuse as helpful impacts whether they occurred within the context of therapy or in nontherapeutic relationships. Similarly, survivors in Feinauer's (1989) study emphasized the importance of an effective support network that sometimes included a therapist but not always.

Participants in Godbey and Hutchinson (1996) qualitative study involving 10 female incest survivors' identified helpful factors that occurred outside of therapy (e.g., having emotionally supportive family and friends) and some that were specific to therapy (e.g., having a therapist they could trust). In addition, numerous impacts that are relevant both within and outside of therapy were identified as helpful to healing: being committed to healing, achieving some stability (e.g., no acute depression or active alcohol/drug use), working through feelings (e.g., grief, abandonment, betrayal, anger, loss of control), developing insight and being willing to change, experimenting with new behaviours, assigning responsibility solely to the abuser, finding joy in life, and accepting the abuse as part of one's past (Godbey & Hutchinson, 1996). While these studies include both intra-

and extra-therapy impacts experienced by clients as helpful, many studies restricted their examination of helpful events to therapeutic situations only.

Edmond, Sloan and McCarty (2004) investigated the perceptions of survivors of childhood sexual abuse regarding the effectiveness of treatment (i.e., EMDR and eclectic therapy). One of the questions that participants were asked included "In what way, if any, was the therapy helpful to you?". Of those women who had attended eclectic therapy, progress was seen as connected to a positive therapeutic relationship that involved support, acceptance, validation and nonjudgment. The women described benefiting from developing skills such as imagery, relaxation, cognitive strategies and being empowered. The women who experienced EMDR described benefiting tremendously from the resolution of core issues, the cessation of negative feelings, and shifts in perceptions of themselves and others (Edmond et al., 2004).

Nineteen male survivors of childhood sexual abuse who participated in a qualitative study regarding healing described therapy as a "journey" and the therapist as a "guide" (Draucker & Petrovic, 1997). The men identified six therapist traits that they perceived to be most helpful: being informed about male sexual abuse issues, informing the client about the therapeutic process (e.g., what to anticipate, setting goals), being connected to the client (e.g., close professional relationship; a clicking), respecting the client's process (e.g., being sensitive to the client setting pace and direction), going the whole distance with the client (e.g., having patience, perseverance and availability), and letting the client go or ending at the right time (e.g., referring out when necessary or ending when appropriate) (Draucker & Petrovic, 1997).

Armsworth (1989) explored clients' perspectives of what helped healing for 30 female incest survivors who had attended therapy. The women had utilized a total of 113 professionals and had spent an average of 36 sessions, approximately 9 months, in helping relationships. Participants identified four categories of interventions as helpful in therapy: (1) validation; (2) advocacy; (3) empathic understanding; and, (4) absence of contempt, punishment, or derision (Armsworth, 1989).

Additional information about helpful aspects of therapy for survivors of sexual abuse can be gained by examining literature regarding group therapy and treatment programs for survivors. Features of group therapy that survivors have described as helpful include being able to share with others, feeling understood, learning they were not alone, realizing they were not as different as they thought, and being able to talk openly about the abuse (Carver, Stalker, Stewart & Abraham, 1989). In addition, survivors of childhood sexual abuse also identified catharsis, self-understanding and cohesiveness (Bonney et al., 1986; Wheeler, O'Malley, Waldo, Murphey and Blank, 1992); family enactment (Bonney et al., 1986); learning to take ultimate responsibility for one's life, vicarious learning, acceptance and self-disclosure (Wheeler et al., 1992); and feeling welcomed, accepted, believed and supported by group members (Hall & King, 1997) as helpful aspects of group therapy.

In a qualitative study regarding helpful aspects of an inpatient treatment program for individuals who had experienced childhood abuse, the aspect of treatment most frequently identified as helpful included interactions with professionals who were described as knowledgeable, competent, supportive, accessible, and respectful (Palmer et al., 2004). Support was seen as including encouragement, empathy and validation. Other aspects of the program participants found helpful included doing emotional work (e.g., discovering, understanding, accepting, addressing and working through emotions), participating in process groups, learning skills and techniques to help oneself (e.g., boundaries, assertiveness, self-care, visualization, journaling), developing a sense of community, gaining insights, gaining information or knowledge, and creating and maintaining safety (Palmer et al., 2004). Although these helpful aspects were identified based on inpatient treatment and group interventions, they include factors that may be experienced as helpful to survivors in general (e.g., support, emotional work, gaining information).

Since information about survivors' experiences of what helps in therapy as they heal from childhood sexual abuse is limited, additional knowledge can be extrapolated from research regarding effective therapy with clients who struggle with issues other than childhood sexual abuse. The remainder of this literature review will examine research focused on clients' perceptions of helpful aspects of therapy for individuals with a variety of presenting issues.

In an early study examining helpful event in counselling, Elliott (1985) had volunteers act as pseudo-clients by participating in a brief counselling session and then describing what was most helpful about the session. Through cluster analysis, two main aspects of helping interactions were identified: *Task* and *Interpersonal*. In the cluster or group related to Task, helpful events involved developing new perspective, solving problems, clarifying the problem, and focussing attention. In the group related to Interpersonal aspects, helpful events included understanding, client involvement, reassurance, and personal contact (Elliott, 1985). Much of the early research examining helpful events in counselling implemented categorical systems that were defined by researchers (Lietaer, 1992; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988). While this early research provided useful information to develop our understanding of helpful events in counselling, pre-defined or researcher-defined systems of classifying information that were used limited the responses received since they imposed what researchers conceived as important experiences onto the findings and these conceptions may not reflect what clients believe are helpful (Elliott & James, 1989).

Wilcox-Matthew, Ottens and Minor (1997) investigated significant helpful events in counselling as reported by clients. This study implemented a qualitative methodology that involved having clients complete questionnaires after counselling sessions and through responses to questions, articulate significant, helpful events. The helpful events described by clients were subsequently analyzed and classified as dissonant, question-answer or congruent. Dissonant events involved the counsellor challenging a maladaptive view that was rigidly held by the client and the client subsequently modifying the original view. This challenging of views was done through reframing, challenging clients' logic, confronting or asking introspective questions. Question-answer incidents involved the client directly or indirectly asking for an explanation or answers due to confusion about an issue and the therapist's responses or interpretations being accepted as helpful and meaningful. Finally, congruent events were ones that involved the counsellor strengthening or reinforcing something presented by the client. These significant events did not involve challenging or changing previously held beliefs, but rather, reinforcing or affirming clients for responses or behaviours they were already doing (Wilcox-Matthew et al., 1997).

Using in-depth interviewing and concept mapping, Paulson et al., (1999) examined helpful aspects of counselling. The findings of this research were consistent with previous research that had described helpful aspects of therapy as including: counsellor facilitative interpersonal style, counsellor interventions, generating client resources, new perspectives, and client self-disclosure (Paulson et al., 1999; Elliott & James, 1989). However, this research also identified new areas that clients perceived as helpful: emotional relief, gaining knowledge, accessibility, and client resolutions. It was suggested that new categories emerged in this study because the information collected by the researchers was not limited or constrained by predetermined categories or coding systems (Paulson et al., 1999).

In a qualitative study investigating helpful aspects of couples therapy, Bowman and Fine (2000) reported that clients described helpful experiences as including being able to trust the therapist (e.g., seen as enhanced by validation, supportiveness, nonjudgment, genuine interest, genuine caring, and transparency of the therapist), feeling safe within the session (e.g., session rules, closure at end of session), having choice (e.g., clients finding own answers, determining session focus, not having to think like therapist, not feeling pressured by therapist), being treated equally (e.g., both partners heard and acknowledged), having the therapist refocus the session, and having therapy as an opportunity to focus on relationship issues. In addition, the clients indicated that gaining a new understanding of their relationship, learning to see themselves in a more positive light, gaining new ideas about gender differences, and making links between sessions were also helpful (Bowman & Fine, 2000). While some of these helpful aspects of therapy appear more relevant to couple counselling (e.g., each partner treated equally by therapist and having opportunity to focus on the marriage or relationship), it seems reasonable that other helpful aspects identified may have relevance to therapy in general as well as to therapy with survivors specifically (e.g., feeling safe, trusting the therapist, having choices).

Implications of Existing Literature

The purpose of this literature review was to provide a foundation for the present study. Childhood sexual abuse is a problem in our society and it has significant long-term effects (Alter-Reid et al., 1986; Blume, 1990; Briere & Elliott, 2003; Browne & Finkelhor, 1986; Cahill et al., 1991; Cole & Putnam, 1992; Holmes et al., 1997; Levy & Orlans, 1998; Lisak, 1994; Mullen, 1993; Putnam, 2003; Stosny, 1995). Given the prevalence of survivors in clinical populations, it is clear that most mental health professionals will work with survivors of childhood sexual abuse (Cahill et al., 1991; Feinauer, 1989; Suffridge, 1991). Existing research based on client perceptions of what contributes to and interferes with healing from childhood sexual abuse is limited (Glaister & Abel, 2001; Hill & Alexander, 1993). For these reasons, the topic of what helps and hinders healing when overcoming childhood sexual abuse merits further research.

Given that many survivors of childhood sexual abuse experience few negative effects, it is important to gain an understanding of what may reduce the negative effects and what contributes to recovery (Davis & Petretic-Jackson, 2000). When individuals are actively involved in their healing process outside of therapy sessions, their healing is positively impacted (Malmo & Laidlaw, 1995). Yet, many researchers address *healing* and *therapy* as if they are synonymous, neglecting to separate intra-therapy impacts from extra-therapy ones. Information specific to what survivors of childhood sexual abuse believe helps and hinders their healing is limited, particularly with regard to factors outside of therapy. Thus, when examining what is helpful and hindering to healing from childhood sexual abuse, this research project seeks to understand the impacts that occur both within and outside of therapy.

The existing literature regarding survivors healing from childhood sexual abuse has been described as over-reliant on therapists' perceptions (Beutler & Hill, 1992; Bonney et al., 1986; Hill & Alexander, 1993). While this clinical literature has offered valuable insight into understanding healing, clients and therapists frequently have differing perspectives and therapists are often unaware of these differences (Caskey et al., 1984; Dill-Standiford et al., 1988; Fuller & Hill, 1985; Thompson & Hill, 1991). Because of these differences in perception, research that includes the perspective of survivors is needed to further our understanding of healing. It is important that the perspectives of survivors inform our understanding of what is helpful and hindering when overcoming childhood sexual abuse. Thus, this research focuses on the perspectives of the survivors themselves.

Qualitative research that incorporates the perspectives and voices of survivors healing from childhood sexual abuse has begun to emerge (Draucker, 1992; Glaister & Abel, 2001; Kondora, 1993; Lisak, 1994). These descriptive studies provide valuable information and insight into the survivor's experience and perspective. However, most of the studies about helpful and hindering impacts to healing continue to involve only or primarily females (Armsworth, 1989; Bonney et al., 1986; Carver et al., 1989; Feinauer, 1989; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall & King, 1997; Malmo & Laidlaw, 1995; Valentine & Feinauer, 1993; Wheeler et al., 1992). Male childhood sexual abuse survivors have been under-represented and possibly under-indentified as victims (Briere & Elliott, 2003; Walker et al., 2004). More recent writings have begun to reflect the experiences of men (Dorais, 2002; Draucker & Petrovic, 1997; King, 1995; Lisak, 1994). However, the need for research that includes both genders has been clearly identified in the existing body of literature (Walker et al., 2004). In order to further our understanding of survivors' perceptions of helpful and hindering impacts on healing from childhood sexual abuse, this study includes the perceptions and experiences of both males and females.

Reviewing the literature on survivors' perspectives of factors that hindered their healing from childhood sexual abuse reveals a lack of information, particularly regarding hindering impacts that occurred outside of therapy situations. One study specifically mentioned hindering influences outside of therapy (Glaister & Abel, 2001) while the remaining studies focused on hindering impacts experienced by survivors who attended individual therapy (Armsworth, 1989; Draucker & Petrovic, 1997), group therapy (Hall & King, 1997) or an inpatient treatment program (Palmer et al., 2004). The remaining studies that that inform our understanding of hindering factors continue to involve therapy situations, but include clients with a variety of presenting issues (Bowman & Fine, 2000; Elliott, 1985; Lietar, 1992; Llewelyn et al., 1988; Paulson et al., 2001). It has been suggested that clients are hesitant to reveal their negative feelings about therapy even when the therapeutic relationship is experienced and described as positive overall (Bowman & Fine, 2000; Hill, Thompson, Cogar & Denman, 1993; Paulson et al., 2001). Additional research examining hindering factors both within and outside of therapy is needed to bring further clarification and understanding.

Research regarding helpful impacts that occur in individual therapy when healing from childhood sexual abuse offers guidance as to what survivors experience as helpful in therapy. Additional information about survivors' perceptions of helpful experiences is gained by considering findings based on survivors' perceptions of helpful impacts in group therapy. For example, helpful factors such as feeling understood, being able to talk openly, and developing self-understanding have been identified as helpful factors in group therapy and it seems plausible that these impacts might also be pertinent in individual therapy. However, the relevance of the research on helpful impacts in groups is limited since some of the helpful aspects include qualities that are not necessarily present in individual therapy such as being part of a cohesive group, learning vicariously, and learning they were not alone or different (Bonney et al., 1986; Carver et al., 1989; Wheeler et al., 1992).

Since literature regarding survivors' perceptions of helpful therapy impacts is somewhat minimal, studies including individuals who attend counselling to resolve issues other than childhood sexual abuse have also been reviewed in order to gain additional insight regarding clients' experiences of helpful events in therapy. Many of the early studies, however, are based on short-term counselling experiences (Elliott, 1985; Hill et al., 1988; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988), some studies involve pseudo-clients who were specifically recruited for the research project (Elliott, 1985; Martin & Stelmaczonek, 1988), and some of the therapists involved were inexperienced (Elliott, 1985). Of those studies that are based on true clinical populations, the clients were often involved in therapy to resolve issues less complicated or traumatic than childhood sexual abuse (Hill et al., 1988; Llewelyn et al., 1988). In addition, many of these early studies used predetermined categorizing systems that may have resulted in researchers' assumptions shaping or limiting the information received (Elliott, 1985; Elliott & James, 1989; Hill et al., 1988; Lietaer, 1992; Llewelyn et al., 1998; Martin & Stelmaczonek, 1988; Wilcox-Matthew et al., 1997). It has been suggested that, rather than using measures based on researchers' conceptualizations, future research needs to incorporate the client's perspective and be more qualitative and exploratory in nature (Elliott & James, 1989; Paulson et al., 1999).

More recently, research utilizing qualitative strategies has allowed for a more complete understanding of client perceptions of helpful impacts during individual (Paulson et al., 1999) and couple therapy (Bowman & Fine, 2000). This study aims to further develop our understanding of healing from childhood sexual abuse by specifically focussing on the perceptions of survivors and their experiences in therapy and by using a concept mapping approach to minimize the researcher's impact on the findings and to maximize the involvement of the participants throughout the process.

In summary, sexual abuse is a serious problem in our society and with it comes the potential for severe short-term and long-term negative consequences. This research project seeks to build upon existing research by exploring what male and female survivors believe helps and hinders healing from the sexual abuse they experienced in childhood. This study uses a concept mapping approach, allowing for information to be collected from participants without imposing a structure or categorizing system on the information. It is hoped that our knowledge regarding what helps and hinders healing—both within and outside of therapy—will be enhanced, thereby providing direction and guidance to both survivors and to the mental health professions who support them.

Chapter 3: Methodology

A review of the literature regarding childhood sexual abuse reveals a need to examine the experience of healing and overcoming abuse from the perspectives of survivors themselves. The purpose of this study was to gain a deeper understanding of what survivors experience as helpful and hindering as they heal from childhood sexual abuse. By using a concept mapping approach, survivors have been provided with a collective voice to identify what helped and what interfered with their healing. This chapter provides an overview of the concept mapping approach and then describes the participants involved and the procedures followed.

Concept Mapping: An Overview

Concept mapping is a structured conceptualization process which can be conducted in a variety of ways, all of which result in ideas being represented as a relatively easy to understand picture or map (Kunkel & Newsom, 1996; Paulson et al., 1999; Trochim, 1989b; Wiener, Wiley, Huelsman & Hilgemann, 1994). It is a participant-oriented process that starts with very specific ideas or generated statements and progresses to more general concepts. Through concept mapping, a group is able to "articulate ideas, assign objective meaning to those ideas, and represent the results in the form of a physical map" (Wiener et al., 1994, p. 232). With concept mapping, an approach that combines qualitative and quantitative strategies, subjectivity can be reduced while studying more qualitative data that have typically been analyzed using non-statistical approaches (Daughtry & Kunkel, 1993).

Since concept mapping emphasizes the participants' perspectives, it allows for constructs to be described as participants experience them, rather than as researchers define them (Daughtry & Kunkel, 1993; Paulson et al., 1999; Trochim, 1989b). Concept mapping has three basic components: a) generating ideas, thoughts or experiences by participants about a specific question; b) grouping together of the ideas, thoughts or experiences through an unstructured card sort; and c) analyzing the card sort results using multidimensional scaling and cluster analysis (Trochim, 1989b; Wiener et. al., 1994).

Generating Ideas

The first process in concept mapping involves having an identified group of participants generate ideas, thoughts, or experiences about a specific research question

(Daughtry & Kunkel, 1993; Trochim, 1989b). Ideally, statements about the topic of interest should be collected until no new information is being presented so that the set of statements generated represents the whole conceptual domain for the topic being researched or mapped (Trochim, 1989b, 1993).

Once the statements from all of the participants have been collected, they are qualitatively analyzed and edited in order to remove irrelevant statements, eliminate jargon and awkward wording, establish consistency of verb and noun tense, remove redundancies and ensure that each statement is detailed enough to be understood when read independently (Kunkel & Newsom, 1996; Trochim, 1989b). Throughout the editing process, the participants' language is retained as much as possible. Typically, the final set should include less than one hundred statements since larger numbers seem to impose considerable practical limitations (Trochim, 1989b). This process results in a final set of non-redundant, qualitative, descriptive statements that capture the essence of the participants' experiences and that become the items used for further analysis (Daughtry & Kunkel, 1993; Kunkel & Newsom, 1996; Paulson et. al., 1999).

Grouping of Ideas

Once the final set of statements has been generated, the next process in concept mapping involves structuring the statements (Trochim, 1989b). It is during this phase that the interrelations among the ideas are measured (Wiener et. al., 1994). For the structuring of the statements, each statement is printed onto an individual slip of paper and a second group of participants is asked to sort and rate each item. Through an unstructured card sort procedure, statements are grouped together on the basis of their similarity or relatedness in a way that makes sense to the participants (Daughtry & Kunkel, 1993; Rosenberg & Kim, 1975; Trochim, 1989b, 1993).

The rules of this sorting process are that each statement can only be placed in one pile, all statements cannot be put into a single pile, and all statements cannot be put into their own pile (Trochim, 1989b, 1993). In other words, statements can only be used once and there can be as few or as many piles as a participant wants; however, there cannot be only one pile and there cannot be as many piles as there are statements. Since participants are not told what dimensions or attributes are to be used for judging similarity when sorting the statements, "the identification of underlying dimensions or attributes can take place from the structures obtained by scaling and clustering, leaving the respondent's judgments uncontaminated by an investigator's preconceptions" (Rosenberg & Kim, 1975, p. 490).

When structuring the statements during concept mapping, some researchers also request that participants complete a rating scale that indicates how much importance, priority, effort, similar experience or expected outcome is associated with each statement (Daughtry & Kunkel, 1993; Kunkel & Newsom, 1996; Trochim, 1989b). These ratings are often completed using a five or seven-point Likert-type scale and the researcher uses these ratings to calculate an arithmetic mean that reflects the endorsement of each statement by the participants (Kunkel & Newsom, 1996; Trochim, 1989b).

Analysis of Data

Once the task of sorting the statements has been completed, two separate multivariate statistical procedures are applied to the data resulting in the structure of the final concept map. These procedures include nonmetric multidimensional scaling (MDS) and hierarchical cluster analysis (Trochim, 1989b; Wiener et. al., 1994). Through statistically analyzing the card sorts, the organizational principles implicit in the participants' sorting are reflected.

Multidimensional Scaling. Multidimensional scaling is a set of procedures that are used to spatially represent the inter-relationships between individual items (Everitt, Landau & Leese, 2001; Fitzgerald & Hubert, 1987). The general purpose of MDS is to uncover the dimensions used by participants to make similarity judgments (Everitt et al., 2001). MDS does not create dimensions that are linear composites of the original variables and thus it is considered a "nonlinear" form of factor analysis (Blashfield, 1984). Unlike factor analysis, MDS does not require that data have interval scale properties (Blashfield, 1984). Typically, MDS is used in conjunction with cluster analysis to visually represent the underlying structure of the data (Blashfield, 1984).

Before beginning MDS, it is necessary to compute individual matrices for each of the sorted items based on the groupings compiled by each sorter. The results from all sorters are combined, thereby producing a group similarity matrix (Everitt et al., 2001; Trochim, 1989b). Using a two-dimensional nonmetric solution, the MDS procedure is then conducted with the data from the group similarity matrix. As a result, the similarity matrix is reproduced as a set of points placed into a bivariate distribution that is suitable for plotting on an X-Y graph where the distance between any two points is a reflection of the frequency with which the items were sorted together (Buser, 1989; Davison, Richards & Rounds, 1986; Fitzgerald & Hubert, 1987; Kruskal & Wish, 1978). Each item represents a single statement and the statements that were grouped together by more people are closer to each other on the map while those statements that were less frequently grouped together are more distant from each other. Thus, the distance between points on the map (i.e., statements) represents the frequency with which the statements were sorted together (Buser, 1989; Daughtry & Kunkel, 1993; Trochim, 1989b).

Since one of the primary purposes of concept mapping is to display the results visually, a two dimensional solution is usually used because it is more easily understood than solutions with more dimensions (Everitt et al., 2001; Kruskal & Wish, 1978; Kunkel & Newsom, 1996; Trochim, 1989b). Multidimensional scaling has been shown to be effective for describing latent relationships among variables by spatial representation, especially when those relationships have yet to be identified (Fitzgerald & Hubert, 1987; Kruskal & Wish, 1978).

The MDS procedure results in a final stress value that represents an overall index of the stability of the MDS solution (Trochim, 1993). A stress value of 0 indicates a perfectly stable solution whereas a stress value of 1.0 indicates a perfectly unstable solution (Daughtry & Kunkel, 1993). It has been suggested that a value of less than 0.30 represents a reasonably stable MDS solution whereas a stress value over 0.40 indicates data that are not consistently sorted into any thematic way (Trochim, 1993).

Cluster Analysis. Once the multidimensional scaling analysis has been completed, the resulting configuration is analyzed using cluster analysis, a classification technique that forms homogeneous groups within complex sets of data (Borgen & Barnett, 1987). According to Davison et. al. (1986), "Cluster analysis represents structure in terms of qualitative categories; MDS represents structure in terms of quantitative dimensions" (p. 182). Hierarchical cluster analysis uses the point map generated through the MDS and divides the points on the map into groups of statements or ideas—that is, into clusters. Through cluster analysis, sorted items are grouped into internally consistent clusters and the cluster solution is superimposed on the multidimensional scaling point map.

Presumably, the statements in each group or cluster reflect similar concepts, thereby representing a conceptual domain (Daughtry & Kunkel, 1993; Kunkel & Newsom, 1996; Trochim, 1989b). It is important to note, however, that when interpreting the map, the MDS solution (i.e., the relative distance and position of items on the map) is given primary consideration over the cluster solution (Paulson et al., 1999). Using cluster analysis along with MDS allows for inferences about how participants categorized items and suggests the dimensions that underlie the categorizations (Kunkel & Newsom, 1996).

Since it is the data and map from the MDS that is used in the cluster analysis, the position of each statement or point on the map never changes. However, the way in which the statements are grouped into clusters changes depending on how many clusters are in the final solution. When doing cluster analysis, there are numerous ways in which to combine groups in order to form a new group (Edelbrock, 1979; Romesburg, 1990). One widely used method is Ward's (1963) minimum variance method and it is the algorithm that was implemented during this study. Ward's method begins by considering each statement as its own cluster and then combines single statements or groups of statements that result in the least increase in the within-in groups sums of squares (i.e., error sums of squares) (Edelbrock, 1979; Everitt et al., 2001; Romesburg, 1990). At each stage of analysis the algorithm combines two clusters until, eventually, all statements form one cluster. At each stage of the grouping, the variance within clusters is minimized. It has been suggested that in the concept mapping process Ward's method of combining groups "generally gave more sensible and interpretable solutions" (Trochim, 1989b, p.8) and is more effective for discovering underlying structures than other methods (Aldenderfer & Blashfield, 1984; Blashfield, 1984; Borgen & Barnett, 1987).

Deciding on the number of clusters for the final map is often one of the most difficult steps in the data analysis. Selecting too few clusters may lead to clusters including items that do not make sense, but selecting too many clusters can make the interpretation of the map very difficult (Trochim, 1993). Trochim (1989b) recommends that all cluster solutions from about three to 20 be examined in order to determine which solution is most representative and he cautions that it is better to err on the side of more clusters than fewer. Also, in order to maintain the integrity of the multidimensional scaling results, the final cluster analysis should not divide the clusters in a manner that involves overlapping clusters (Trochim, 1989b).

When deciding on the number of clusters that best represent the information, bridging values can be of great assistance. A bridging value or index is a number that can potentially range between 0 and 1, with higher numbers reflecting that the item or statement is more likely to be a bridge between two or more areas to which it is related (Trochim, 1993). Likewise, if the bridging index is low, then the statement is not a bridging item and it is more probable that the statement was sorted mainly with statements that are near it on the map (Trochim, 1993).

The bridging index assists the researcher in determining whether an item on a concept map is an accurate representation of the space in which it is located or whether it has been located in a certain place due to a compromise by the multidimensional scaling algorithm (Trochim, 1993). For example, an item with a higher bridging value indicates that it is related to and bridges two or more areas and suggests that the statement was more likely to have been sorted with statements that were further away from it. At the extreme, a bridging value of 1.0 suggests that the item could potentially be sorted with every cluster. Conversely, a low bridging value indicates that items within a cluster were more frequently placed together than with items in different clusters.

Average bridging values can be calculated for each cluster. A cluster with a higher bridging average will be less homogeneous and therefore more difficult to interpret whereas a cluster with a low bridging value generally represents a more coherent set of statements (Trochim, 1993). Since a low bridging value reflects that a statement is not a bridging statement but rather is closely associated to the statements near it, those statements with low bridging index values provide the best insight as to the general concept in a given area of the map (Trochim, 1993).

Once the most appropriate cluster solution has been identified, each cluster is given a label or name that represents the theme or concept described by that cluster. This process of naming clusters can be done by the participants who generated and/or sorted the statements or by the investigators themselves. Since clusters which are closer together on the map tend to have more similarities than clusters which are farther apart, there may be certain clusters that go together and that can be grouped into “clusters of clusters” or

regions and these regions can also be given a name (Trochim, 1989b, 1993). The names for each cluster, and region if appropriate, are then added to the cluster map and the final map "constitutes the conceptual framework and the basic result of the concept mapping process" (Trochim, 1989b, p. 11). Once the concept map has been developed, it can also be used as the framework for displaying and interpreting the ratings that were previously reported by the participants during the sorting and rating tasks (Trochim, 1993). The information from the ratings may be graphically included in the final map if desired.
A final concept map is "a pictorial representation of the group's thinking which displays all of the ideas of the group relative to the topic at hand, shows how these ideas are related to each other" (Trochim, 1989b, p. 2). In the end, the result is a clear and concise summary of the conceptualization of the participants. At a glance, each map shows all of the major ideas and their interrelationships.

Rationale for Concept Mapping

Concept mapping was chosen as an appropriate method for the research question regarding helpful and hindering factors to healing from childhood sexual abuse because it is a structured, participant-oriented process that permits the study of constructs as experienced by participants rather than as defined by researchers (Daughtry & Kunkel, 1993).

Concept mapping involves participants in item generation, data gathering and sorting of statements and it combines qualitative and quantitative research strategies, thereby increasing confidence in the results (Daughtry & Kunkel, 1993; Wiener et al., 1994). Since participants are active in the concept mapping process, there is less researcher's bias than in other qualitative research methods that tend to rely on having only the researcher(s) sort the data into themes or groups (Paulson & Edwards, 1997; Paulson et al., 1999; Wiener et al., 1994). In concept mapping, bias is further reduced since it uses statistical procedures such as MDS and cluster analysis to examine qualitative data (Paulson & Edwards, 1997; Paulson et al., 1999; Wiener et al., 1994).

One of the assets of concept mapping is that many of the tasks involved—generating, sorting, and rating statements—are relatively easy to perform and the resulting map is clear and easily understood by both participants and other interested individuals. The final concept map is a graphic representation that illustrates all of the major ideas and their interrelationships at a single glance (Trochim, 1989b, 1993).

Concept mapping is "an alternative methodological approach that is particularly appropriate for applications in which researchers are seeking to clarify the domain, constituent elements, and underlying structure of a phenomenon as experienced within the population of interest" (Daughtry & Kunkel, 1993, p. 317). It begins with very specific ideas or generated statements and progresses to more general concepts. Concept mapping has been applied to a variety of areas in psychology. For example, it has been used to explore constructs such as hindering experiences in counselling (Paulson et al., 2001), images of god (Kunkel, Cook, Meshel, Daughtry & Hauenstein, 1999), challenges faced by foster parents (Brown & Calder, 1999), helpful experiences in counselling (Paulson et. al., 1999), client presenting problems (Kunkel & Newsom, 1996), vocational stress in Protestant clergy (Miller, 1996), giftedness (Kunkel, Chapa, Patterson & Walling, 1995), and depression in college students (Daughtry & Kunkel, 1993). It appears that, to date, no research has utilized the concept mapping approach to develop a conceptual understanding of what helps and hinders when healing from childhood sexual abuse. Thus, concept mapping appears well suited to the task of increasing our understanding of what survivors of childhood sexual abuse experience as helpful and hindering as they heal.

Data Collection—Phase I

Before beginning this research, ethical approval to conduct this study was obtained from the Department of Educational Psychology Research and Ethics Committee at the University of Alberta. After receiving approval, the first phase of data collection focused on generating the ideas or statements that described the participants' experiences of healing so that the descriptive statements could be used in later phases of the research. What follows is a detailed description of the participants involved and the procedures followed in order to generate the ideas for this research project.

Participants

Participants were sought from a variety of sources including mail outs to psychologists, announcements in newsletters, postings on internet support groups and on-line bulletin boards, and word-of-mouth. Participants were solicited on a volunteer basis and were required to be "at least 21 years old", to have "experienced sexual abuse in childhood", and to "feel that they have achieved at least a fair or moderate degree of healing or recovery". The definition of what to include in terms of sexual abuse was left open so that any sexual activities that the participants felt were abusive could be included. In all, 63 information packages were given out in person, by mail, or by e-mail. Of these, 56 completed questionnaires were returned. This represented a response rate of approximately 89%. Borg and Gall (1989) suggest that this response rate is sufficient enough not to worry about the findings being altered considerably by those who did not respond.

Characteristics of the Sample. The non-random, purposive sample of 56 participants included 37 females and 19 males (approximately 66% and 34% of participants respectively). This is relatively comparable to estimates in the literature that have indicated that 70% of all victims are female while approximately 30% are male (Bolen, 2001; Finkelhor et al., 1990; Holmes et al., 1997; Russell, 1983). The age of respondents ranged from 21 to 62 years old, with a mean of 40.2 ± 9.4 years (based on 55 participants since one respondent did not provide his age). The mode and median age were both 41 years. Most participants were Caucasian (80.4%), however numerous other backgrounds were represented: First Nations Canadian or Native American (5.4%), Australian (5.4%), African American (1.8%), British (1.8%), Hispanic (1.8%), and Iranian (1.8%). One woman declined providing her ethnic/cultural background.

With regard to family composition, of the 56 participants, approximately 57% identified themselves as being in a live-in relationship (i.e., 41.1% were married, 12.5% were re-married, and 3.6% were common-law). The marital status of the remaining participants was described as never-married (21.4%), separated or divorced (19.6%), and widowed (1.8%). The number of children for participants ranged from 0 to 4, with almost three quarters of the participants having at least one child (71.4%).

Characteristics of the Abuse Experienced. Information regarding the number of times each person was sexually abused indicated that almost three-quarters of the participants experienced sexual abuse "over 20 times" (73.2%) while 3.6% of respondents experienced it "11-20 times" and 21.4% experienced it "2-10 times". No participants reported experiencing only one incident of sexual abuse and one woman's answer was unclear as she wrote "I don't know" as a response. This frequency of sexual abuse represents a slightly higher occurrence than suggested by other studies which indicate single episodes of abuse are reported for approximately one-forth of cases in clinical samples and one-half of cases in non-clinical samples (Berliner & Elliott, 2002). Although no participants in this study reported only a single episode of abuse, about one-quarter of the participants did indicate that the abuse occurred on fewer than 10 occasions.

When considering the age at the time the abuse was experienced, responses were grouped according to several age ranges: 6 years old or younger, 7-12 years, 13-17 years. Two participants did not respond to this question, but of the remaining 54 participants 63.0% described experiencing abuse at the age of six years old or younger, 74.1% indicated they experienced abuse between seven and 12 years old, and 59.3% reported that they experienced abuse between the ages of 13 and 17 years old. Keeping in mind that most people experienced sexual abuse more than twenty times, this suggests that many people experienced ongoing abuse or that the abuse occurred in more than one developmental period.

The 56 participants identified having experienced sexual abuse from a total of 283 different offenders--259 males (91.5%) and 24 females (8.5%). Although a non-random, purposive sample was used, this gender difference of offenders is similar to other studies that have suggested that approximately 1% to 20% (Romano & De Luca, 2001) or 5% (Bolen, 2001) of offenders are female. Most people had one or more male offenders (92.9%) while only just over one-quarter of the participants (26.8%) had one or more female offenders.

For each participant, the number of offenders committing the sexual abuse ranged from one to 30. One-quarter of the participants (25%) identified having a single offender and one fifth (20%) indicated that they had two offenders. At the other end of the continuum, approximately one fifth of the participants reported having had 10 or more offenders, with two of these participants (3.6%) reporting abuse from 30 offenders. One of the participants who reported having been abused by 30 offenders explained that her abuse involved being prostituted out by a family member. A more detailed examination of the number of offenders is presented in Table 1.

It is difficult to compare the number of offenders each survivor experienced abuse from to figures in existing literature since the number of offenders is rarely reported.

However, one study involving 181 borderline patients with a history of childhood sexual abuse reported that approximately 35% of the women had experienced abuse by a single offender, 25% from two offenders, and 40% from three or more offenders (Zanarini et al., 2002). When considered according to a similar breakdown, it seems that, on average, the participants in the current study experienced abuse by more offenders. Fewer survivors in the current study report having only one offender (25% vs 35%), fewer indicate having two offenders (20% vs 25%) and more report having three or more offenders (55% vs 40%).

Table 1. Number of Offenders

Number of Offenders	**Number of Survivors**	**Percent of Survivors**
1	14	25.0
2	11	19.6
3-9	20	35.7
10-19	8	14.3
20-29	1	1.8
30	2	3.6
Total	56	100

Three-quarters of the 283 offenders (75.6% or 214 offenders) were known to the victims (i.e., relatives or acquaintances) while 17.3% were strangers (the other 7.1% were not clearly identified as either known or unknown). This proportion falls within the range identified by Finkelhor (1994) who reported that 10 to 30% of offenders are strangers and is very close to the range of 5% to 15% being strangers suggested by Berliner and Elliott (2002). In the current study 82 of the 283 offenders referred to were described as being related (29.0%), 195 of them (68.9%) were identified as not related and six of them (2.1%) were not clearly defined as to whether or not they were related. This is very similar to previous research that has indicated that approximately 30% of all abuse occurs within the family, while the remaining 70% is extra-familial (Bolen, 2001). For this project, Table 2 provides a more specific delineation of the relationships represented by the 82 offenders who were clearly identified as related to the survivors.

Table 2. Relationship of Offenders to Survivors

Relationship	**Number**	**Percent**
Father or step-father	20	24.4
Brother	15	18.3
Uncle or step-uncle	13	15.8
Cousin	9	11.0
Grandfather	7	8.5
Mother	6	7.3
Grandmother	2	2.4
Sister	2	2.4
Brother-in-law	1	1.2
Niece	1	1.2
Identified only as "relative"	6	7.3
Total	82	99.8[a]

[a] Does not equal 100% due to rounding errors

Previous studies have suggested that of relatives who abuse, uncles are the most frequent offenders, followed closely by father-figures and cousins (Bolen, 2001). These three types of relatives comprise three of the four most common relatives who perpetrated abuse experienced by the participants. However, brothers emerged as a relative that was also frequently identified as an offender and fathers were reported to be the offender more than any other group. Abuse by parental figures is believed to constitute approximately 6-16% of all abuse cases (Berliner & Elliott, 2002). For this study, the figures are comparable with 26 out of 283 offenders being parental figures (9.2%). In the current study, almost one-quarter of the participants (23.2%) were not related to any of their offenders.

Healing and Therapy. Participants were asked to endorse statements that reflected how much they believed they had healed or overcome the abuse. Nobody indicated that they believed the abuse had not affected them or that they "haven't healed much at all". About 11% of participants believed they had started healing, but were only in the early stages. Approximately 36% of participants indicated that they were "about half-way through" their healing while 48% indicated they felt they were "almost done" healing since they had "overcome almost all of the negative effects of the abuse". The remaining 5% of participants indicated that they believed they had "overcome the negative effects" and were "completely healed". Thus, in summary, almost 90% of participants believed they were at least half-way or more through their healing, with over half (53%) believing they were "almost done" or "completely healed".

While only one of the 56 participants identified never having attended therapy, almost one-quarter (23%) of the participants indicated that the therapy they did attend was not focused on the effects of the sexual abuse and one-fifth (20%) of the people reported having attended 20 or fewer counselling sessions. More specifically, the 56 participants described their involvement as outlined in Table 3.

Table 3. Survivors Involvement with Therapy

	Females	Males	Total
Was the therapy you attended focused on the abuse?			
Yes	31 (55%)	11 (20%)	42 (75%)
No	5 (9%)	8 (14%)	13 (23%)
n/a	1 (2%)	0	1 (2%)
Total	37 (66%)[a]	19 (34%)	56
How many sessions did you attend?			
0 (no therapy)	1 (2%)	0	1 (2%)
1-5	0	0	0
6-10	4 (7%)	1 (2%)	5 (9%)
11-20	2 (4%)	3 (5%)	5 (9%)
>20	30 (54%)	15 (27%)	45 (80%)
Total	37 (66%)[a]	19 (34%)	56

[a]Does not add equal 100% due to rounding errors

As this table reveals, 75% of the participants who were involved in generating ideas for the question regarding therapy had counselling focused specifically on the effects of the abuse. The other 25% either attended therapy but reported that it was not for issues specifically related to sexual abuse (23%) or did not attend therapy (2%). In addition, it is important to note that 20% of the participants are providing their responses after having no therapy or relatively short-term counselling encounters (involving less than 20 sessions) while 80% of participants attended more than 20 sessions.

Summary of Participants. As the above description illustrates, this phase of the research included a larger sample (n=56) than many of the previous studies involving the perspective of survivors (Armsworth, 1989; Bonnney et al., 1986; Glaister & Abel, 2001; Wheeler et al., 1992). In addition, the inclusion of both males and females is significant since most studies regarding helpful and hindering impacts when healing have been restricted either primarily (Malmo & Laidlaw, 1995) or exclusively to females (Armsworth, 1989; Bonnney et al., 1986; Carver et al., 1989; Feinauer, 1989; Glaister & Abel, 2001; Wheeler et al., 1992). Furthermore, the participants for this research represented a diverse group with respect to characteristics such as age and family composition, although most participants were Caucasian (80%).

It is important to highlight that, as a group, the purposive sample of participants in this research experienced sexual abuse that had very similar characteristics and proportions to the characteristics and rates of sexual abuse described by previous studies. All of the participants in this study experienced childhood sexual abused on multiple occasions, with three-quarters of them reporting that it occurred over 20 times. Participants described being abused during different developmental periods through either multiple occurrences or ongoing abuse. Participants reported experiencing sexual abuse by male versus female offenders as well as by strangers versus relatives or acquaintances in similar proportions as to what existing literature estimates occurs in society. One difference suggests that more participants in the current study reported a greater number of offenders than what has been noted in previous literature. Although the sample was not random or representative in terms of statistical properties, the similarities in characteristics of victims, of the abuse experienced and of the offenders involved increase the face validity of the results.

Another significant characteristic of this sample is that one-quarter of the participants indicated that they had either never attended therapy or never attended therapy that focused on the effects of the abuse. Furthermore, one fifth of the participants indicated they attended less than 20 counselling sessions. Having some participants whose healing did not focus centrally on involving therapy was deemed important in order to include the helpful and hindering aspects of healing that occurred outside of therapy.

The survivors in this phase of the study, who were recruited to share their experience of helpful and hindering impacts on their healing, are believed to be able to illuminate the experience of healing from childhood sexual abuse.

Procedure

People who indicated an interest in participating in the first phase of this research were given a package of information consisting of a description of the study, a demographics form and a questionnaire. The study description (Appendix A) outlined what was involved in participating in the study as well as clarifying participants' rights (e.g., the right to withdraw at any time without penalty). The demographics form (Appendix B) gathered information used to describe various characteristics of the participants and the abuse they experienced. The questionnaire (Appendix C) consisted primarily of three open-ended questions aimed at obtaining the survivors' descriptions of their experiences of healing--what helped them heal, what interfered with their healing, and in therapy what did they find helpful. Participants were also given the opportunity to provide any other comments about what helped or interfered with healing. The questions were focused enough to bring forth survivors' perspectives yet ambiguous enough not to unduly influence their responses. Care was taken in order to not shape or limit the responses received (e.g., such as focusing on a specific dimension of experiencing like feelings, thoughts or behaviours).

Since it was anticipated that *therapy* would be a significant factor in healing, it was asked about separately so that helpful aspects of healing not related to therapy would also emerge and so that more detailed information about what helps in therapy would be obtained. Previous research had indicated a need for qualitative research regarding clients' perspectives (Elliott & James, 1989; Paulson et al., 1999) and survivors' perspectives (Glaister & Abel, 2001; Hill & Alexander, 1993) regarding therapy so the inclusion of a question focused specifically on helpful aspects of therapy was seen as one way to respond to that identified gap in the literature.

An open-ended questionnaire method was chosen in order to avoid pre-defining or influencing the nature of the responses received. The questions were intended to be detailed enough to elicit information about the topic without shaping the information according to any predetermined characteristics (e.g., feelings, events, beliefs). Using questionnaires have been found to have advantages over methods such as interviewing because questionnaires may increase participants' openness since there is greater neutrality and anonymity, they eliminate interviewer biases, and they allow participants time to consider their responses before returning them to the researcher (Judd, Smith & Kidder, 1991). In addition, a questionnaire format allows for a larger sample to be included without the task of gathering ideas becoming unmanageable Judd et al., 1991; McLeod, 1994).

Through the Study Description (Appendix A), usually the first written information seen about the research project, potential participants were informed of their rights. In order to ensure that consent was informed, the importance of having read the Study Description was mentioned on both the demographic form and the questionnaire. Participants were informed that by returning the questionnaire and demographic form they were providing their consent to participate in the project. Potential participants were instructed not to sign their name on the forms, allowing for anonymity. Any electronic communication regarding this research was conducted through an e-mail address established solely for the purpose of this study and protected by a password known only to the researcher. Since many of the questionnaires were completed by individuals who heard about the study via the Internet, sometimes identifying information such as e-mail addresses were present on the responses. When questionnaires with identifying information were returned, such information was removed and all participants were assigned and subsequently referred to by a number.

The responses from each package were transcribed and grouped according to the three questions posed on the questionnaire. The probe requesting additional information elicited responses about helpful and hindering events in general as well as further elaboration of helpful aspects of therapy. Thus, the descriptions shared in the additional comments section were placed into the category they best described. This process resulted in the creation of three documents, each one corresponding to one of the three questions and each one containing numbered and verbatim transcripts of the responses given by each of the participants.

These transcribed responses then underwent several stages of analysis aimed at identifying significant statements or meaning units that captured the essence of the healing and that retained participants' language (Daughtry & Kunkel, 1993). Initially, transcripts were edited for spelling, punctuation, and comprehension, ensuring that each sentence could be clearly understood. Statements containing more than one idea were separated into two or more sentences. Then, statements not related to the research question—what helped and what interfered with healing—were removed. For example, contextual or irrelevant statements such as "I think it is important to say that sexual abuse affects every aspect of a person's being" were taken out while potentially relevant statements like "Having a skilled counsellor" were retained. Obvious duplications were removed. When additional participants' responses appeared to be no longer providing new information, saturation was reached and no additional participants were sought.

The analysis to this point resulted in each of the three research questions being reflected by a set of statements describing the participants' experiences in their language. What helped healing was described by 106 statements, what hindered healing was described by 116 statements and what helped in therapy was described by 108 statements. Further analysis focused on comparing the statements within each group and removing redundancies, ensuring that each statement represented a unique idea. For example, statements such as "Learning coping skills", "Learning how to cope with the past", "Learning a lot of different ways to cope" and "Learning how to store flashbacks away in my memory" were combined into the similar, but more inclusive statement, "Learning how to cope with the effects of the sexual abuse".

Similarly, statements that were too specific, relating only to a few individuals or to certain situations, were removed or combined with other statements to reflect a broader idea that would be more applicable to survivors in general. For example, in relation to what helped in therapy, the more global statement "My therapist encouraging artistic ways for me to get in touch with my feelings" was used to represent statements that were deemed too specific such as "Singing and song writing allowed me to express myself", "Reviewing pictures from the various stages of my life [with my therapist]", "Making Native crafts" and "My therapist encouraged creative methods for me to get in touch with a lot of the hurt, pain, shame and events of the past".

All statements were edited to establish consistency of verb and noun tense. For example, “counsellor”, “therapist” and “psychologist” were all changed to “therapist” for consistency and ease of reading. This procedure was used to increase the interpretability of the concept map “through equating the level of abstraction and providing parallel grammatical structure for each item” (Daughtry & Kunkel, 1993, p. 318). In addition, awkward wording was corrected and jargon was removed. Changes from the verbatim responses were kept to a minimum. The researcher completed all of the analysis with continual input from three colleagues, ensuring there was agreement when removing or changing statements. The essential meaning of each statement and the language of the participants were retained during the editing process.

The analyzing and editing of the statements resulted in three lists of non-redundant, qualitative description statements regarding what survivors of childhood sexual abuse found helpful in healing (69 statements), what they believed hindered their healing (70 statements), and what they found helpful in therapy (69 statements). For each question, these statements were typed onto slips of paper and put into a questionnaire for the sorting and rating tasks during the second phase of data collection.

Data Collection—Phase II

The second stage of data gathering involved grouping together the statements or items that were previously collected from the participants. For this task, the three final sets of statements were used in three separate unstructured card sorts. Descriptions of the participants involved for each of the three questions and the procedures followed during this phase of the research are described below.

Participants

Twenty-five of the 56 participants who were involved in phase one of the data collection, agreed to complete the sorting and rating tasks during phase two. Twenty-three of these individuals returned their completed packages. Five additional individuals heard about the research and participated in the sorting and rating tasks. Therefore, in all, 30 packages were sent out and 28 packages were returned (i.e., 23 individuals who participated in both phases and five who participated only in the sorting and rating tasks). Potential participants had been given the choice of sorting the statements for one, two or all three of the questions. All of the participants chose to sort all three questions, with the exception of one participant who did not sort the statements regarding what was helpful in therapy since she had never attended therapy.

This group of 28 participants were the survivors who engaged in the sorting and rating tasks for each of the three questions. However, on occasion a participant's sort was excluded resulting in a slightly different group of participants for each of the three questions. What follows is a description of the participants involved in each question followed by a summary of the participants overall.

Question #1: Helpful Impacts. All of the 28 packages returned were included in the sorting and rating tasks for the first question. Of the 28 participants, 82% had participated in generating the statements in phase one and 18% were new to the research project. These participants included 21 women (75%) and 7 men (25%). The age range of these participants was 26 to 66 years old with a mean age of 42.6 years ± 9.5. Ninety-six percent of the participants were Caucasian while the remainder was First Nations Canadian. With regard to family composition, half described themselves as being in a live in relationship of some type (e.g., 32% married, 14% re-married, and 4% common-law). The remaining participants included individuals who were separated or divorced (32%) and never married (18%). Participants had between zero and four children, with approximately 68% of the participants having at least one child.

The 28 participants reported abuse from a total of 138 offenders, which included 116 males (84%) and 22 females (16%). The survivors identified knowing 83% of their offenders and being related to 30% of them. The offenders included the following relatives: father or father figure (31%), brother (21%), uncle (14%), mother (12%), grandfather (10%), cousin (7%), grandmother (2%), aunt (2%). Twenty-nine percent of the survivors reported having been sexually abused by at least one female while 93% experienced abuse by at least one male. All of the survivors reported multiple incidents of abuse, with 93% of respondents suggesting they were abused more than 10 times. Although all were abused on multiple occasions, nearly a third of the participants (29%) had a single offender and three quarters of the participants had fewer than five offenders. The survivors described having experienced abuse during many developmental stages with 61% being abused at age six or younger, 82% between the ages of seven and 12, and 54% between the ages of 13 and 17.

Participants endorsed statements that subjectively reflected how much they believed they had healed from or overcome the abuse. Nobody believed that they had "not healed much at all" and only 7% indicated that they had either "just begun" or were in the "early stages" of healing. Twenty one percent of participants believed that they were "at least half-way" through their healing, while 64% suggested they had "overcome almost all of the negative effects" and another 7% indicated they were "completely healed". Thus, 93% of participants felt they had achieved at least half of the healing necessary and 71% believed they had overcome all or most negative effects.

Attending therapy was common among participants with 96% reporting having attended therapy and 82% indicating that they attended more than 20 sessions. In addition, 82% of the participants indicated that they attended therapy focused on the effects of the abuse.

Question #2: Hindering Impacts. All of the 28 participants from phase two sorted the statements related to this question. However, a closer examination of the data revealed problems in the unstructured sorts of two of the participants who had each placed all of the statements into just two piles. While this is not specifically a violation of the sorting instructions, it could be a reflection of not understanding the task or of lacking motivation for the task. On the other hand, it could rightfully represent how they divide the categories. Nevertheless, it has been noted that when participants create larger, more generic categories, the interpretability of the map suffers (Miller, 1996). Trochim et al. (1994) advises "excluding lumpers from the analysis may make the results more interpretable" (p.771). For this reason, the two sorts that consisted of only two piles each were eliminated from this study.

As a result of eliminating two of the sorts from the results, the sample of participants for this question consisted of 26 participants, including 19 women (73%) and 7 men (27%). The age of the participants ranged from 26 to 66 years, with an average of 42.5 ± 9.9 years. Of the 26 participants, 85% had participated in generating the statements in phase one and 15% were new to the research project. Ninety-six percent of the participants were Caucasian while the remainder was First Nations Canadian. Approximately half (54%) of the respondents described themselves as being in a live in relationship of some type (e.g., 35% married, 15% re-married, 4% common-law).

Participants who were separated or divorced (27%) and never married (19%) comprised the remainder of the group. Survivors in this study had between zero and four children, with approximately two-thirds (65%) having at least one child.

The 26 participants reported abuse from a total of 130 offenders, which included 108 males (83%) and 22 females (17%). The survivors identified knowing 84% of their offenders and being related to 32%. Offenders included the following types of relatives: father or father figure (29%), brother (22%), uncle (15%), mother (12%), grandfather (10%), cousin (7%), grandmother (2%), aunt (2%). Almost one-third of the survivors (31%) indicated that they had been sexually abused by at least one female and 8% indicated that they were abused by only females. On the other hand, 92% experienced abuse by at least one male and 69% indicated that they had been abused by only males. All of the participants reported multiple incidents of abuse, with 92% of respondents suggesting they were abused more than 10 times. Although all were abused on multiple occasions, 27% of the participants had a single offender and three quarters (77%) of the participants had fewer than five offenders. Abuse was described as occurring during many developmental stages with 65% of the survivors indicating it occurred at age six or younger, 85% between the ages of seven and 12, and 50% between the ages of 13 and 17.

In order to gain a sense of where survivors felt they were in terms of their healing, participants were asked to endorse subjective, descriptive statements regarding how much they believed they had healed. Nobody believed that they had "not healed much at all" and only 8% indicated that they had either "just begun" or were in the "early stages" of healing while the remaining 92% felt they were half-way or more through their healing process. More specifically, 23% endorsed statements that suggested being "half-way through", 62% indicated they had "overcome almost all of the negative effects" and 8% described themselves as "completely healed". Among participants doing the sorting and rating tasks for this question, 96% reported that they had attended therapy and 81% described their therapy as focused on the effects of the abuse. In addition, 85% of the participants indicated that the therapy they attended involved greater than 20 sessions.

Question #3: Helpful Therapy Impacts. Of the 28 survivors who participated in the sorting and rating tasks for this research project as a whole, 27 of them completed the tasks for this question. One person did not rate or sort these statements since she had never experienced being in therapy. Thus, participants for this question included 20 female (74%) and seven male (26%) survivors who had attended therapy. Their ages ranged from 26 to 66 years and their mean age was 42.3 ± 9.6 years. Of the 27 participants, 81.5% had participated in generating the statements in phase one and 18.5% were new to the research project. As in the other questions, Ninety-six percent of the participants were Caucasian while the remainder was First Nations Canadian. Just under half (48%) of the respondents described themselves as being in a live in relationship of some type (e.g., 30% married, 15% re-married, 4% common-law). The remaining individuals were separated or divorced (33%) and never married (19%). Participants in this study had between zero and four children, with 70% having at least one child.

The 27 participants described having been abused by a total of 137 offenders, which included 115 males (84%) and 22 females (16%). All of the survivors experienced multiple incidents of abuse, although 26% had a single offender. The number of incidents of abuse was quite high with 92% of participants indicating they were abused more than 10 times; this number drops only slightly to 82% reporting that they were sexually abused on more than 20 occasions. Abuse was described as occurring during many developmental stages with 59% of the survivors indicating it occurred at age six or younger, 85% between the ages of seven and 12, and 56% between the ages of 13 and 17.

The survivors identified knowing 83% of their offenders and being related to 30%. Offenders included the following types of relatives: father or father figure (32%), brother (22%), uncle (12%), mother (12%), grandfather (10%), cousin (7%), grandmother (2%), aunt (2%). Almost one-third of the survivors (30%) indicated that they had been sexually abused by at least one female and 7% indicated that they were abused by only females. On the other hand, 93% experienced abuse by at least one male and 70% indicated that they had been abused by only males.

Since this question focused on helpful event in therapy, all of the participants had attended therapy. Most participants (85%) report that their therapy was focused on the effects of the abuse and only 15% of the participants indicated attending fewer than 20 sessions. As mentioned previously, participants were asked to endorse statements related to how much they believed they had healed. Of the participants involved in this question, nobody believed that they had "not healed much at all" and only 7% indicated that they had either "just begun" or were in the "early stages" of healing. The remaining 93% believed they were half-way or more through their healing process. More specifically, 22% endorsed statements that suggested being "half-way through", 63% indicated they had "overcome almost all of the negative effects" and 7% described themselves as "completely healed".

Summary of Participants. All of the participants in this phase of the research described experiencing multiple incidents of sexual abuse, usually by more than one offender (74%). The abuse often occurred during multiple developmental stages and perpetrators included both men (83-84%) and women (16-17%). Most of the offenders were people known to the victim (83-84% and many were identified as relatives (30-32%). These reports are similar to those found in previous studies which indicate that 70% to 90% of offenders are people known to the victim (Finkelhor, 1994) and that 1% to 20% of offenders are female (Romano & De Luca, 2001). For each of the three questions, the groups of participants varied slightly due to occasional exclusions. While the question involving helpful impacts included all 28 of the participants, the question regarding hindering impacts involved only 26 survivors and the one focused on therapy impacts included 27 participants. In order to ensure the slight changes to the groups did not alter the groups in a significant way with regard to age or gender, groups were compared to one another. As well, the three groups in this phase of the research were compared to the larger group of participants from Phase I who assisted with the generating of statements. Table 4 provides an overview of the composition of the various groupings of participants.

Table 4. Overview of All Participants According to Gender and Age

	Number of Participants	Gender		Average Age (in years)
		Females	Males	
Questionnaire (used to generate statements)	56	37 (66%)	19 (34%)	40.2
Question #1 (What helped with healing?)	28	21 (75%)	7 (25%)	42.6
Question #2 (What hindered healing?)	26	19 (73%)	7 (27%)	42.5
Question #3 (What helped in therapy?)	27	20 (74%)	7 (26%)	42.3

A one-way ANOVA on the basis of age and Chi-square analyses on the basis of gender revealed no significant differences (p>.05) between any of the groups. That is, with regard to age and gender, there were no statistical differences between each of the three groups of survivors who sorted and rated the statements nor were there any differences between the three groups in Phase II and the larger group in Phase I.

The majority of participants in this study believed they were at least half-way through their healing journey, with most indicating they were "almost done" or "completely healed". While most individuals had attended therapy (96-100%), some participants described attending less than 20 sessions (15-18%) and some indicated that their therapy was not focused on the effects of the abuse (15-19%). Many participants in this phase of the study had been involved in the first phase (82-85%). The procedures followed during Phase II, including the sorting and rating tasks completed by these participants, are described next.

Procedure

Research packages were mailed to individuals who agreed to participate in this second phase of data gathering which involved sorting and rating tasks in order to group together the ideas generated earlier. Each package contained the following information: a letter describing the study (Appendix D), a listing of what each participant is to do (Appendix E), a demographic and information sheet (Appendix F), a checklist of completed tasks (Appendix G), and a self-addressed return envelope (with postage if within Canada or with a form to complete and return for postage reimbursement if outside of Canada). In addition, all of the packages contained three smaller envelopes, one per question. Each of these smaller envelopes was labelled with the appropriate question number and contained the sorting instructions (Appendix H) and statements to be sorted (i.e., each statement typed onto an individual slip of paper) as well as the rating instructions (Appendix I) attached to a listing of the statements to be rated (Appendix J).

In order to avoid statements being sorted with the wrong group, each of the three questions was color-coded. For the packages, the written directions and color-coding proved to be clear and effective since none of the participants mixed up the statements for the different questions and all tasks were completed properly. Alterations to packages were made as required. For example, the small package pertaining to Question #3 (what helped in therapy) was removed for the participant who had never attended therapy.

The covering letter (Appendix D) described the purpose and nature of the study and outlined each participant's rights. It was explained that by returning the completed sorting and rating tasks they were providing informed consent to participate in the project. The researcher's contact information was provided in the event that participants had questions or required further explanation.

Upon receiving the research package, the main task involved having each participant sort the statements that were generated by the survivors in the first phase of the research. Each of the three questions was treated independently, with the statements pertaining to a specific question only being sorted with other statements of that same question. As mentioned previously, each statement was typed onto an individual slip of paper and the participants were asked to sort the statements into groups in a way that made sense to them, based on similarity of content or meaning. The sorting instructions (Appendix H) explained that statements could be kept separate if they did not seem to fit with the others and the only restrictions placed on how the statements were sorted required that there had to be more than one pile, each statement could not be its own pile, and each statement could only be placed into one pile (Rosenberg & Kim, 1975; Trochim, 1989b, 1993). The goal in this phase of the research was for the participants to group the statements into categories or themes.

In addition to having the master list of statements for each question written on slips of paper for the sorting task, the statements were also compiled into a questionnaire for the rating task. Participants rated each item on a five-point Likert-type scale according to how helpful or hindering each item was in their experience (Appendix J). Dobson and Mothersill's (1979) recommendations regarding equidistant categorical labels informed the decisions regarding the number of categories and the labels selected for each category of this scale. For the questions about what helped healing and what helped in therapy, each statement was rated between a "1" (not at all helpful) and a "5" (extremely helpful). For the question regarding what interfered with healing, each statement was rated on a similar scale, but the word "interfering" was substituted for "helpful" so that, for example, a "5" corresponded to a statement that represented something that was "extremely interfering".

These ratings were based on participants' own experiences and allowed for a way to assess the endorsement of each statement by the participants. The rating value for each statement reflects an average of all of the participants' perceptions of the degree that each item was helpful or interfering. The rating value for each cluster can also be calculated by finding the average of the ratings of all of the statements within a given cluster (Trochim, 1993).

Participants who did not return their packages within approximately three weeks were contacted by telephone or e-mail. Of the thirty packages mailed out, 28 were returned resulting in a response rate of 93%. The two participants who did not return their packages indicated that they did not have the time to complete them due to unexpected circumstances and withdrew from the study. Ninety-three percent is considered an acceptable response rate (Borg & Gall, 1989).

Analysis of Data

After following the procedures outlined above, each of the three sets of data obtained from the unstructured card sorts and the rating tasks was analyzed independently using two statistical procedures: nonmetric multidimensional scaling (MDS) and cluster analysis. Through these procedures, the organizational principles implicit in the participants' sorting are reflected.

Multidimensional Scaling

Analyzing the information pertaining to one question at a time, the first step in the MDS procedure involved calculating individual similarity matrices for the sorted statements within a given data set. Then, these individual similarity matrices were combined, resulting in a group similarity matrix with as many rows and columns as there were items. As previously described, a nonmetric MDS procedure was applied to the similarity matrix resulting in each statement being represented by an X-Y coordinate and being plotted as a point along orthogonal axes. A two-dimensional solution was used since it is more useful and easier to understand than solutions with more dimensions (Kruskal & Wish, 1978; Kunkel & Newsom, 1996; Trochim, 1989b). This process resulted in the creation of three maps, one pertaining to each of the three questions, where each point on the map represents one of the statements generated by participants.

Statements that are plotted on the map as points closer to each other represent items that were placed together in the participants' sorts more frequently than statements represented by points more distant from each other. Presumably, items near one another were more likely to be related to the same concept while those statements that were less frequently grouped together were more distant from each other on the map and had less in common. The map is "intended as a statistical mirror of the underlying organization strategy used by participants in their sorting of items" (Kunkel et al., 1995, p. 128).

Cluster Analysis

After the items or statements were plotted as points on a map as a result of the MDS analysis, the next task involved using cluster analysis to group the sorted items into clusters that were internally consistent, thereby presumably reflecting similar concepts or a common theme (Trochim, 1989a). As described previously, this research applied Ward's (1963) minimum variance method in order to combine groups into new clusters since its techniques are more effective for discovering underlying structure than other clustering strategies (Borgen & Barnett, 1987). Ward's method combines single statements or groups of statements in a way that minimizes the variance within clusters, thereby providing more sensible and interpretable solutions. When combined with MDS, cluster analysis allows for inferences to be made regarding how participants categorized items and what dimensions may underlie the categories or clusters. Both the MDS and cluster analysis procedures were conducted through the Concept System[1] computer program.

For each of the three maps, numerous cluster arrangements were considered by visually inspecting point and cluster maps as well as by examining bridging values. In accordance with recommendations by Trochim (1989b), cluster solutions ranging from three to 20 clusters were superimposed on the MDS point map for consideration, noting the changes that occurred as groups were split or combined and assessing whether the groupings made sense. Deciding upon which cluster solution best suited the data was done by examining the statements in each grouping for similarities, by considering bridging values as a reflection of how well the items belong together, by avoiding overlapping clusters whenever possible and by using discretion and common sense when making decisions (Trochim, 1989b). The goal was to decide upon a cluster solution that maximized the interpretability of the maps and the distinctiveness of the clusters.

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[1] Concept mapping analysis and results conducted using The Concept System software: Copyright 1989-2002; all rights reserved. Concept Systems Inc.

As mentioned previously, bridging indices for individual items and average bridging values for each cluster, provide valuable information about how well the statements belonged together and were therefore used as a guide to make decisions regarding the appropriate number of clusters for each of the three maps. When examining individual statements, the lower the bridging value, the more likely it was that the item was sorted more frequently with the statements close to it on the map. For clusters, the lower the average bridging value for the cluster, the more likely it was that the statements within it represented a common theme. In order to determine which cluster solution was the most accurate depiction of the underlying concepts, the statements in each grouping were examined for similarities, seeking to have each cluster represent a unique idea or concept. Attempts were made to achieve a cluster solution that did not allow any clusters to overlap in order to maintain the integrity of the multidimensional scaling analysis (Trochim, 1989a).

After the researcher completed the initial analysis for each question, two research assistants reviewed several of the cluster maps and corresponding listings of statements and bridging values in order to offer feedback regarding the best cluster solution for each question. Particular attention was paid to the shifts that occurred as the possible number of clusters increased or decreased, to the existence of overlapping clusters, and to bridging indices. Feedback was thoroughly considered before final decisions were made regarding the most appropriate cluster solution, solutions that would allow discrete themes to emerge without over-generalizing the results. In accordance with recommendations by Aldenderfer and Blashfield (1984), a detailed description of the procedures used and criteria considered when deciding upon the final cluster solution for each map is outlined below.

Helpful Impacts. An examination of the maps showing possible cluster solutions regarding what helped survivors heal revealed that solutions with 11 or more clusters appeared fragmented, with very few statements in some of the clusters and no clear themes emerging. Until a nine-cluster solution was examined, two of the clusters in the lower-right quadrant of the map overlapped. Although the overlapping disappeared by the nine-cluster solution, there were other concerns. It seemed that in the upper left quadrant of the map, Cluster 7 (statements 5, 45, 37, and 66) and Cluster 8 (statements 8, 57, 51, 23, 63 and 39) contained similar ideas. For example, the four statements included in Cluster 7 all referred to the "offender", but so did two of the statements in Cluster 8 (i.e., statements 51 and 63). Since these clusters were close to each other on the map, it seemed that the ideas fit together and the two groups could be combined. These statements did become combined in an eight-cluster solution. However, in the eight-cluster solution, a similarity in ideas or themes was seen between two of the clusters in the lower-right quadrant. Thus, a seven-cluster solution was examined since it joined the two clusters that seemed to have similar themes.

The seven-cluster map seemed to offer an appropriate cluster arrangement, but before deciding on this solution, a six-cluster solution was examined in further detail. In the six-cluster solution, two of the groups in the upper-right quadrant were combined to make a single cluster. However, analysis of the individual statements suggested that, although the clusters were small, the clusters did accurately represent two unique and separate concepts and were better left as separate clusters. Solutions with five, four or three clusters were judged to produce an overgeneralization of the results, combining concepts that were unique when left separate. In the end, a seven-cluster solution was determined to be the most accurate way to represent the concepts that survivors of childhood sexual abuse described as helpful as they healed from the abuse. It seemed that this solution eased interpretability of each cluster and maximized the differences between them.

Hindering Impacts. When examining the possible cluster maps for the question related to hindering impacts, groupings were fragmented with few distinct themes emerging until the map with 10 clusters was considered. At the other end of the spectrum, inspection of maps with three, four and five clusters revealed large groupings that suggested an overgeneralization of the statements. Themes began to emerge more clearly when a six-cluster map was examined. Thus, it was believed that the most appropriate grouping would involve somewhere between six and 10 clusters.

Analysis returned to the ten-cluster solution in order to consider the individual statements within some of the smaller groupings and to compare the statements across groupings to determine if each set of statements suggested a unique representation of an idea. The two clusters on the far right of the map seemed to contain numerous statements that were similar. For example, one of the clusters revealed a theme of people not being supportive as evidenced by statements such as “Not being believed by others”, “Having other people resent my healing”, “Having contact with people who were unsupportive” and “Having unsupportive family members”. The adjacent cluster seemed to reveal this same theme with items that included “Other people making insensitive comments”, “Having people support my offender instead of me” and “Having an unsupportive spouse”. Since these two groupings seemed to be referring to the same concept, the division into two separate clusters was determined to be inappropriate and unnecessary. Further evidence for joining the two clusters was provided by an examination of the impact of such an adjustment on the bridging index. Separately the clusters had bridging values of 0.34 and 0.32 and when the two groups were combined, the bridging value for the single cluster became 0.33, suggesting that combining the groups did not compromise the cohesiveness of how the statements belonged together.

Having determined that these two clusters needed to be collapsed into a single grouping, the analysis shifted to the remaining maps to detect when such a partition would occur. Examination focused on an eight-cluster solution where the separate groups became united into one cluster. This eight cluster solution appeared to be a possible solution since it seemed to allow conceptual themes to be represented by the various clusters, however, arrangements with fewer clusters also needed to be considered.

Attention then shifted to the seven-cluster map, which involved the second and third clusters from the eight-cluster map being combined into a single grouping. The individual items of the two clusters in question certainly had similarities to each other both within and between clusters, as would be expected given their close proximity on the map. However, it seemed that combining the two clusters provided an overgeneralization of the concepts, giving up specificity and uniqueness. Statements in the third cluster seemed to reflect themes of isolation and denial (e.g., “Believing that no one cared”, “Believing that there was nobody I could turn to for help”, “Not wanting to believe the abuse happened” and “Keeping the abuse hidden from people who were important to me”). Whereas, for the other cluster, the items seemed to suggest an absence of hope and safety (e.g., “Believing that there was little hope of ever healing from the abuse”, “Having my safety and/or the safety of my family threatened”. When these two clusters were combined, the bridging index was 0.25 for the single cluster, only a minimal change from the bridging values when they are separate (i.e., 0.26 and 0.25).

After considerable reflection, it was decided that the qualitative descriptive information that was added by separating the clusters was significant. The seven-cluster map was deemed to be an over-generalization of the survivors' perceptions of what hindered or interfered with their healing. Analysis of the six-cluster solution was unnecessary since it continued this process of combining unique clusters into broader groupings. Thus, the researcher selected an eight-cluster solution as being the most interpretable and representative of the underlying concepts.

Helpful Therapy Impacts. For the question related to helpful aspects of therapy, the various maps displayed fragmented clusters that sometimes contained only one or two statements and few apparent themes until an eight cluster solution was examined. With the eight-cluster solution, themes began to emerge and it was clear that the final map would include no more than eight groupings. However, on this map, the lower right quadrant posed a problem since it contained overlapping clusters and overlapping clusters threaten the integrity of the MDS procedures (Trochim, 1989a; Trochim et al., 1994).

By examining solutions that allowed two of the groups in this region to overlap, possible reasons for the difficulties were revealed. When the individual items in the two overlapping sets were examined, it became clear that the groupings, while independent of each other in some ways also had common characteristics. Cluster 1 seemed to be addressing supportive behaviours of the therapist while Cluster 2 appeared to be more concerned with qualities of the therapist or therapeutic relationship. It is very difficult to separate supportive behaviours of the therapist from the therapeutic relationship in which those behaviours occur. For example, it has been argued that empathy and the therapeutic relationship are intricately and inextricably connected (Wampold, 2001). The inter-connectedness of the therapist and the therapy itself is illustrated by Wampold (2001) who states "The particular therapist delivering the treatment is absolutely crucial....The essence of therapy is embodied in the therapist" (p. 202).

When considering the dilemma of the overlapping clusters, the bridging indices were examined. The two overlapping clusters had very low bridging indices (Cluster 1 = 0.11 and Cluster 2 = 0.05) suggesting that the clusters did fit well together. Thus, it was accepted that the final map would contain two overlapping clusters in the bottom right quadrant representing the therapist and the therapeutic relationship. Although this solution contained the less than ideal problem of overlapping cluster, some reassurance was offered by Aldenderfer and Blashfield (1984) who contend that Ward's method of clustering outperforms other clustering strategies in conditions of cluster overlap.

To this point in the analysis, inspecting various clustering arrangements had revealed that the final concept map would include somewhere between five and eight clusters. Fewer than five clusters displayed a clear overgeneralization of the results. Examination of an eight-cluster solution, however, revealed that it divided the lower right quadrant into four clusters and the cluster that became divided no longer seemed to represent unique concepts. Examination of a map with seven groupings seemed to allow conceptual themes to emerge through all of the various clusters. Although the overlap between Clusters 1 and Cluster 2 existed, it seemed to make logical sense since the concepts were closely related. Furthermore, in this seven-cluster solution, the bridging values for these two overlapping clusters were the highest on the entire map (0.11 and 0.05 respectively), indicating that the individual items within each cluster were frequently sorted together by participants. Interestingly, these two clusters also had the highest rating values. In the seven-cluster solution, all of the groupings contained a reasonable number of statements and, for the most part, each cluster seemed to represent a clear and concise theme or idea.

Before accepting this seven-cluster solution, examination focused on the six-cluster solution. The shift from seven groupings to six resulted in combining two clusters located at the top of the map (i.e., eventually labelled as Cluster 5 and Cluster 6). While these two groupings are definitely related, as their close proximity to one another on the map suggests, it seemed that conceptually the items in Cluster 5 reflected more behaviour oriented statements (e.g., recognize effects of the abuse, recall memories, learn assertiveness skills) whereas Cluster 6 seemed to include ideas that involved more profound changes of self (e.g., recognizing self-worth, gaining an understanding of my feelings). It seemed that the seven-cluster solution offered the best differentiation, depicting clusters with unique and descriptive themes.

Map Interpretation

After having decided upon the final cluster solution for each of the three maps, the next task involved identifying themes and labelling or naming each cluster. In addition, since MDS arranges points along horizontal and vertical axes, investigation focuses on identifying possible underlying dimensional patterns (Buser, 1989). The cluster solution is used as a secondary guide to interpreting maps since it is imposed on approximated distances between items from the MDS solution (Paulson et al., 1999).

Labels for each cluster were decided upon by considering the individual statements within each cluster, paying particular attention to the statements with the lowest bridging values since those statements provided the best insight as to the general concept in a given area of the map (Trochim, 1993). After examining statements with a lower bridging index, those items with higher bridging values were considered. When selecting a label, efforts were made to use words or synonyms that were found in the statements generated by participants, thereby retaining their language as much as possible.

Five research assistants were consulted to provide input regarding the labelling of each cluster and the possible dimensional themes. These assistants included four women and one man, ranging in age from 27 to 41 years old, with an average of 35 years. Their professions included two psychologists, one teacher, one physical therapist, and one office manager. Three of the five assistants had experienced childhood sexual abuse. Each assistant was provided with instructions and training regarding how to identify themes and assign labels. Participants were taught about the significance of low bridging values and the importance of retaining the language of the original statements whenever possible. The five participants who assisted with this labelling process returned their packages—with labels added—within one month. Meanwhile, the researcher had also independently identified cluster labels and dimensional themes.

The next step involved combining the original labels decided upon by the researcher and the suggested headings from the five participants into a list for consideration as potential themes or headings. After carefully examining the feedback, and incorporating it when appropriate, names for each of the clusters on the maps were selected. These descriptive names were then reviewed and commented on by the researcher's supervisor, whose feedback was incorporated, thereby resulting in the final labels for the clusters on all three of the maps. In addition to identifying labels for each of the clusters, the assistants had been asked to identify broader themes in the different quadrants of the map or by travelling across the map. Most of the participants found this part of the task challenging, but the feedback received was considered and incorporated into the final results as well.

Conclusion

The purpose of this study is to develop a conceptual understanding of what survivors of childhood sexual abuse perceive as impacting their healing. By responding to an open-ended questionnaire, 56 participants described their experiences of healing. This resulted in three sets of statements, each set representing the survivors' responses to the three questions guiding this research--what has contributed to your healing, what has interfered with your healing, and what in therapy has been helpful.

The responses were analyzed and transformed into non-redundant descriptive statements that reflected the survivors' experiences in their language. Then, for each of the three sets of data, 26 to 28 survivors completed unstructured card sorts and rated each statement according to how they personally experienced it. The information from these sorting and rating tasks then became the data analyzed using multidimensional scaling and cluster analysis procedures. Having the participants complete the sorting process is beneficial since neither the respondents nor the researcher have to specify any of the psychological dimensions or attributes that provide a basis for judgments of similarity. Instead, "the identification of underlying dimensions or attributes can take place from the structures obtained by scaling and clustering, leaving the respondent's judgments uncontaminated by an investigator's preconceptions" (Rosenberg & Kim, 1975, p. 490). Since it is the participants who do the sorting or grouping, the results are not unduly influenced by the researcher's preconceptions or imposition of structure onto the data.

Finally, through qualitatively analyzing the clusters and items within each cluster, the concepts represented by each cluster were identified and labelled and dimensional patterns were noted. This process resulted in three concept maps that represented the participants' experiences regarding helpful impacts, hindering impacts and helpful therapy impacts. All of the findings are presented in the following chapter.

Chapter 4: Results

The findings of this research project will be discussed according to each of the three themes--helpful impacts, hindering impacts and therapy impacts. For each question, a concept map and a summary table of the clusters and items will be presented. In addition, a detailed description of each cluster and an overview of each map as a whole will be provided. The chapter will conclude with a brief summary of all of the findings.

Question #1: Helpful Impacts

As described in the previous chapter, the unstructured card sorts became the data used for the multidimensional scaling (MDS) and cluster analysis which resulted in a concept map that included 69 statements describing helpful impacts that were then grouped into seven themes or clusters. Recalling that the MDS procedure results in a stress value that ranges between 0 (perfectly stable) and 1.0 (perfectly unstable), the final stress value for this concept map was 0.27. Although this value is not ideal, it is considered acceptable and reasonably stable and such a value has been accepted by other researchers (Daughtry & Kunkel, 1993; Knish, 1994; Paulson et al., 1999).

An understanding of survivors' perceptions of what has been helpful to their healing from childhood sexual abuse can be gained by examining the concept map (see Figure 1) and cluster and item table (see Table 5) that reflect their experiences. In addition, a detailed discussion of each cluster and of the map as a whole is provided.

Concept Map for Question #1: What helped you heal from the childhood sexual abuse you experienced?

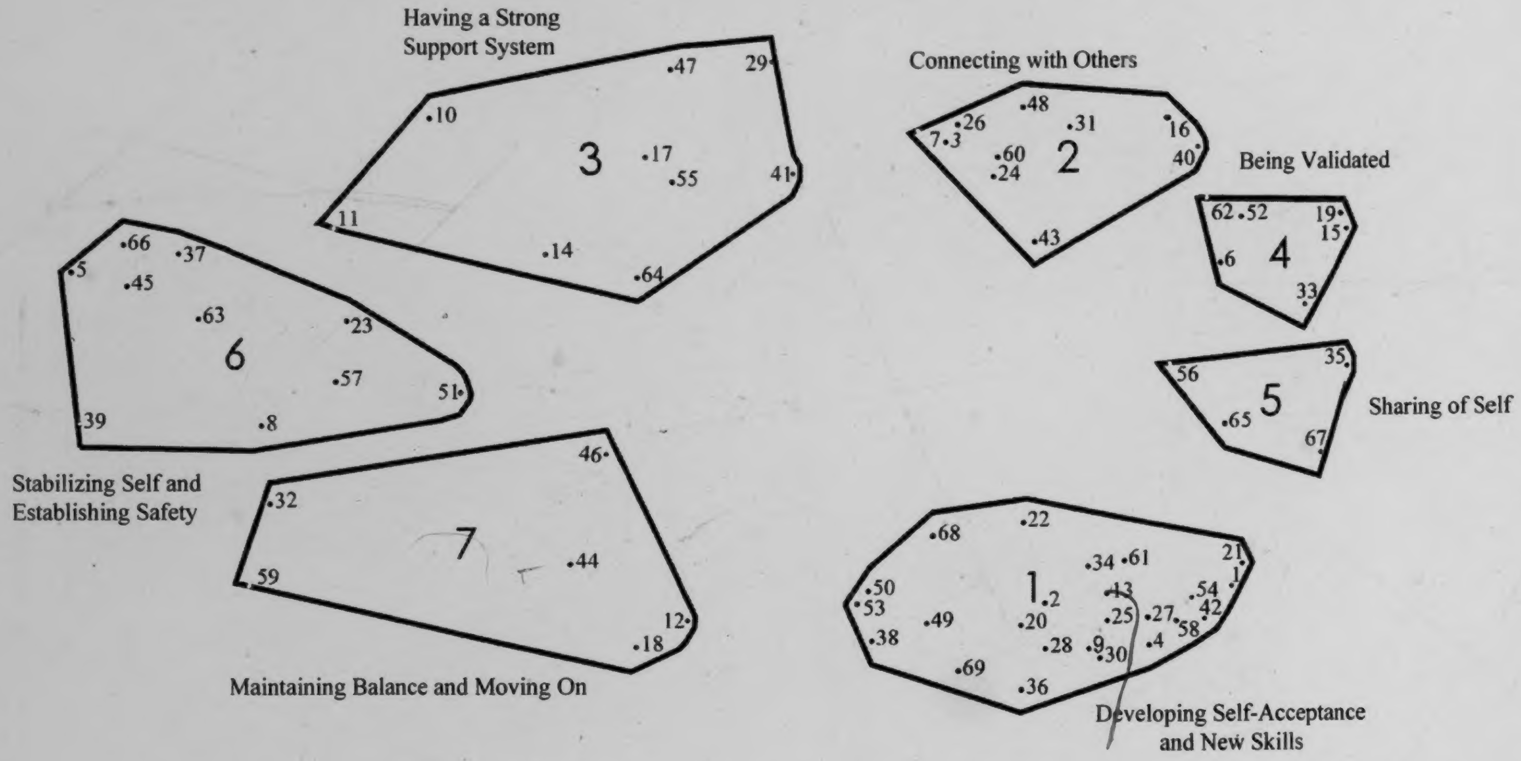
Having a Strong Support System
3
10
47
29
17
55
41
11
14
64
Connecting with Others
2
7
3
26
48
31
16
40
60
24
43
Being Validated
4
62
52
19
15
6
33
Sharing of Self
5
56
35
65
67
Stabilizing Self and Establishing Safety
6
5
66
37
45
63
23
57
51
39
8
Maintaining Balance and Moving On
7
46
32
44
59
12
18
Developing Self-Acceptance and New Skills
1
68
22
34
61
21
1
50
53
2
43
54
42
49
20
25
27
58
38
28
9
30
4
69
36

Figure 1. Concept map of helpful impacts when healing from CSA

Table 5. Clusters and Items from Survivors' Concept Map of Healing Impacts

CLUSTER and ITEM		BRIDGING VALUE	RATING VALUE* (mean)
Cluster 1: Developing Self-Acceptance and New Skills		**0.13**	**3.89**
25.	Learning to be assertive.	0.00	3.93
30.	Learning to be myself.	0.05	4.07
2.	Confronting my fears.	0.06	4.18
4.	Realizing that I can only change myself.	0.06	3.96
27.	Re-examining beliefs I had formed in childhood.	0.06	4.29
9.	Being patient with myself.	0.08	3.68
42.	Learning self-acceptance.	0.08	3.86
13.	Giving myself empowering messages.	0.09	3.36
20.	Forgiving myself.	0.09	3.64
28.	Drawing upon my personal strengths.	0.09	4.46
36.	Being comfortable with all my feelings.	0.09	3.82
54.	Reconnecting with my feelings.	0.10	3.96
34.	Learning how to protect myself.	0.11	3.50
61.	Finding personal strengths that resulted from having been abused.	0.11	4.00
58.	Understanding how the abuse changed my life.	0.12	4.11
49.	Finding creative ways to express myself.	0.17	4.00
22.	Deciding to stop being a victim.	0.18	3.64
69.	Putting the abuse into perspective.	0.18	3.68
1.	Recognizing the ways the abuse connects to issues in my life.	0.20	4.68
68.	Doing journaling.	0.20	3.61
38.	Taking time to care for myself.	0.22	3.61
21.	Learning new ways to cope with the effects of the abuse.	0.23	4.25
50.	Overcoming my own denial about having been abused.	0.23	3.21
53.	Learning that the abuse was not my fault.	0.24	3.79
Cluster 2: Connecting with Others		**0.36**	**3.36**
3.	Receiving support from self-help programs I attended.	0.29	3.07
24.	Other people being non-judgemental.	0.29	3.82
26.	Having someone reach out to me.	0.33	3.57
31.	Connecting with people who were supportive.	0.33	3.96
7.	Being inspired by others who have healed from childhood sexual abuse.	0.34	3.25
60.	Accessing support networks during times of crisis.	0.34	3.07
48.	Connecting with other survivors.	0.36	3.50
43.	Educating others about sexual abuse.	0.37	3.00
40.	People not giving up on me.	0.47	2.89
16.	Accessing various healthcare professionals.	0.53	3.43

Cluster 3: Having a Strong Support System	**0.54**	**2.77**
41. Being able to access support anonymously (e.g., crisis lines or internet groups).	0.38	2.14
29. Having supportive family members.	0.45	2.57
55. Being surrounded by healthy influences away from home when I was a child.	0.48	3.00
64. Speaking out about the abuse to protect other potential victims.	0.49	3.04
14. Having a pet.	0.53	2.21
17. Having someone confirm that the abuse occurred.	0.59	3.96
47. Having a supportive partner.	0.61	2.79
11. Having access to financial assistance to cover the cost of therapy.	0.63	2.96
10. My partner's strength.	0.70	2.29
Cluster 4: Being Validated	**0.50**	**4.30**
62. Being believed.	0.42	4.50
52. Being loved by others.	0.45	3.79
6. Being validated.	0.48	4.50
33. Attending therapy.	0.50	4.57
19. Having other people see my potential.	0.56	3.93
15. Being listened to.	0.58	4.50
Cluster 5: Sharing of Self	**0.45**	**3.79**
56. Telling my story.	0.36	4.39
65. Gaining knowledge about sexual abuse.	0.40	4.07
67. Learning to be open in my relationships.	0.51	3.29
35. Helping other people.	0.55	3.43
Cluster 6: Stabilizing Self and Establishing Safety	**0.68**	**2.28**
5. Never having to see my offender again.	0.56	2.89
51. Forgiving my offender.	0.57	2.36
37. Having my offender admit to having sexually abused me.	0.58	1.29
57. Quitting the use of drugs and/or alcohol.	0.63	1.79
63. Dealing with my offender's denial.	0.63	1.96
23. Taking medication.	0.64	2.68
66. Being protected from the offender when I disclosed the abuse.	0.64	1.96
45. Taking action against my offender.	0.67	2.07
8. Being kept safe from self-destructive behaviours.	0.85	3.11
39. Experiencing the supernatural healing power of God.	1.00	2.64
Cluster 7: Maintaining Balance and Moving On	**0.67**	**3.41**
12. Maintaining a balanced life.	0.44	3.30
46. Having a relaxing home environment as an adult.	0.55	4.14
44. Remembering everything I could about the abuse.	0.56	3.18
18. Feeling safe.	0.62	4.29
32. Having time pass.	0.83	2.79
59. Participating in spiritual practices or rituals.	0.99	2.79

*Participants rated each item according its helpfulness in overcoming childhood sexual abuse based on their experience. The 5-point Likert-type scale ranged from 1 (not at all helpful or not applicable) to 5 (extremely helpful).

Description of Clusters

Cluster 1: Developing Self-Acceptance and New Skills. Located in the bottom right hand corner of the concept map, Cluster 1 has the most statements and lowest bridging value (0.13). Thus, although this is a very large group of statements, the items were sorted together often. With such a low bridging index for the cluster, it is presumed that the cluster generally represents a more coherent set of statements (Trochim, 1993). When this large group was divided in other clustering arrangements, it did not allow for the identification of unique themes or concepts. As well as being the cluster with the lowest bridging value (i.e., sorted with the most consistency), Cluster 1 had the second highest rating average (3.89), suggesting that participants found the items in this cluster helpful. Among the most helpful items identified in this cluster were "Recognizing the ways the abuse connects to issues in my life" (Statement 1) and "Drawing upon my personal strengths" (Statement 28) with average ratings of 4.68 and 4.46 respectively.

Cluster 2: Connecting with Others. Located in the upper right quadrant of the map, Cluster 2 had the second lowest bridging index (0.36). The label for this group of items was chosen directly from one of the statements in the cluster. At first glance, some of the statements in this cluster seem only loosely related to the theme of "Connecting with Others" (e.g., "Educating others about sexual abuse" and "People not giving up on me"). However, all of the statements reflect ideas that involve connection between two or more people. When asked how helpful the statements in this cluster were to healing, the cluster average was 3.36, which reflects a rating between "somewhat helpful" and "pretty helpful".

Cluster 3: Having a Strong Support System. Located in the top left quadrant of the concept map, Cluster 3 contained items that reflected the theme of having a strong support system. This cluster addressed ideas such as accessing support anonymously, having supportive family members, and having a supportive spouse. The bridging value for this cluster was quite high at 0.54, suggesting more diversity among the items than in the previously examined clusters. This diversity can be seen in statements such as "Having access to financial assistance to cover the cost of therapy" and "Having a pet". Within this cluster, these statements were interpreted as financial support and the unconditional love than can come from a beloved pet. Thus, these statements were seen to reflect the general theme of "Having a Strong Support System".

This cluster had the second lowest rating average (2.77) suggesting that these items were, on average, experienced as slightly helpful to somewhat helpful. The three items that received the lowest ratings included "Being able to access support anonymously", "Having a pet", and "My partner's strength". Two possible explanations for these lower averages include that the items were experienced as less helpful than the other influences on healing or, alternatively, these items may not have existed for a significant number of participants. For example, since approximately 18% of the participants have never been married and another 32% were divorced, it may be that "My partner's strength" received a low rating because it was "not applicable" to a significant number of people.

Cluster 4: Being Validated. This cluster received the highest average rating (4.30) of all the clusters, indicating that overall its impact was "pretty helpful" to "extremely helpful". This would suggest that items related to "Being Validated" had a significant contribution to the healing of survivors. The majority of this grouping consisted of statements about being listened to, believed, loved, and validated. The remaining statements included "Having other people see my potential" and "Attending therapy". Clearly, it is validating to have other people recognize one's potential and therapy is intended to be a validating process. This cluster had a bridging index of 0.50, suggesting that either the individual statements or the cluster as a whole may have had a bridging role. This cluster was located in the upper right corner of the map, nestled between Cluster 2 ("Connecting with Others") and Cluster 5 ("Sharing of Self"). All three of these clusters seem to incorporate a broader theme that reflects the importance of relationships with others in healing from childhood sexual abuse.

Cluster 5: Sharing of Self. Comprised of only four statements, Cluster 5 is the smallest of all the groupings. This cluster had a bridging index of 0.45, suggesting it was the third most conceptually similar grouping on the map. It shares the upper right quadrant of the map with two other groupings (Clusters 4 and 2). As mentioned previously, by reducing the number of clusters on this map, this cluster becomes combined with Cluster 4. While both clusters are associated with relationships, the previous cluster seemed more about others reaching out to survivors whereas this cluster seems to be conceptually different in that it describes activities where the survivor is actively risking and sharing of him/her self. For example, the statements include "Telling my story", "Learning to be open in my relationships" and "Helping other people". Although not a perfect fit, the statement "Gaining knowledge about sexual abuse" was interpreted as fitting into this grouping related to sharing of self because often it is after learning the truth about abuse that many survivors are able to tell their story, learn to be open, and reach out to help others. In all of these items, the survivor is *doing* something—telling, gaining, learning or helping. In the previous cluster, most of the statements involved the survivor *being* something by someone else—being listened to, being believed, being loved, being validated.

The items within Cluster 5 had a mean rating of 3.79, the third highest average. The two statements rated as most helpful were "Telling my story" (4.39) and "Gaining knowledge about sexual abuse" (4.07) which reflected experiences that were perceived as "pretty helpful" to "extremely helpful".

Cluster 6: Stabilizing Self and Establishing Safety. This cluster, located in the upper left quadrant of the map, had the highest bridging index (0.68) and as such it contained items that seemed to represent little conceptual similarity. Many of the statements were associated with offender-related issues (5, 51, 37, 63, 66, 45); however, other statements were not at all related to offender issues (57, 23, 8, 39). It was decided that, despite the high average bridging index for the cluster and the apparent lack of a cohesive theme, a seven-cluster solution was still the most suitable.

The theme of "Stabilizing Self and Establishing Safety" was identified as a label that encompassed the majority of the individual items. An increased sense of safety is clearly reflected in the statements "Being kept safe from self-destructive behaviours", "Being protected when I disclosed the abuse", and "Never having to see my offender again". Resolving offender-related issues—including having the offender admit to the abuse, dealing with the offender's denial, or forgiving the offender—would certainly contribute to a sense of stability for oneself as well as possibly increase one's sense of safety. In addition, the tasks "Quitting the use of drugs and/or alcohol", "Taking medication" and "Taking action against my offender" would all help keep a survivor physically safe and increase stability.

The final item in this cluster, "Experiencing the supernatural healing power of God" had a bridging index of 1.0 indicating that it was a bridge between two or more areas to which it was related, potentially having been sorted with every possible cluster. Another item, "Being kept safe from self-destructive behaviours" also had a high bridging index (0.85). These high values suggest that the location of these two items on the map is not a reflection of them having been frequently sorted together. Rather, the high bridging indices suggest these items are bridges between other items on the map and were not consistently sorted in any way.

As well as having the highest bridging index, Cluster 6 had the lowest average rating (2.28) which suggested that participants experienced these items as "slightly helpful" to "somewhat helpful". Upon closer examination, it was discovered that this cluster was the only grouping on the map that included statements with average ratings below 2.0. This cluster had four statements with such low mean ratings (i.e., Statements 37, 57, 63 and 66). With an average rating of 1.29, statement 37 had the lowest value on the entire concept map (i.e., "Having my offender admit to having sexually abused me"). It is believed that this value was low since the statement was "not applicable" to many survivors. By reviewing how each participant endorsed this statement, it was learned that 24 out of the 28 survivors selected a rating of "1" which reflected a response of "Not at all helpful OR Not applicable" (the remaining four ratings included 2, 3, 3, and 4). Although there is no way to determine from the data how many of the 24 ratings of "1" represent lack of experience versus lack of helpfulness, since many offenders never admit to their abusive behaviours, many survivors would not have experienced "Having my offender admit to having sexually abused me". The researcher noted that many participants wrote "n/a" beside the statement when they endorsed it with a "1".

Cluster 7: Maintaining Balance and Moving On. Along the bottom of the map, Cluster 7 is the sole occupant of the lower left quadrant. This grouping of six items has a fairly high index (0.67) and initially appears to have little homogeneity. Even within the cluster, each item appeared visually independent and isolated from the items with which it was grouped. Two of the items, "Having time pass" and "Participating in spiritual practices or rituals" had extremely high bridging indices (0.83 and 0.99 respectively), suggesting that these statements had a tendency to be frequently sorted into many different clusters or to fit in other areas on the map. Having items with such high bridging values in a cluster may excessively inflate the average bridging value for that cluster as a whole. For example, with all six items included, the average bridging index for the cluster is 0.67 whereas when the two items with more extreme bridging values are removed, the average bridging index for the cluster decreases considerably to 0.54.

The items in this cluster seemed to, for the most part, reflect strategies for healing during later stages of overcoming the abuse—maintaining balance, having a relaxing home, participating in spiritual practices, and remembering everything (statements 12, 46, 59 and 44). The focus in this cluster is no longer on early coping skills such as quitting drugs or alcohol (Cluster 6, Statement 57) or on developing insight (Cluster 1, Statements 50 and 53). Rather, the focus is on maintaining a balanced life and moving on—tasks that occur with the passage of time (Statement 32) and by feeling safe (Statement 18).

This cluster had an average rating of 3.41, the third highest of all the clusters, suggesting that as a group the items in this cluster were experienced as "somewhat helpful" to "pretty helpful". Two of the statements—"Feeling safe" and "Having a relaxing home environment as an adult"— were perceived as especially influential in healing with average ratings of 4.29 and 4.14 respectively.

Overview of Map

In response to the question "What has contributed to overcoming the childhood sexual abuse you experienced?" survivors' responses suggest seven unique themes. In addition to examining each cluster individually, inspecting the entire map for patterns or themes can provide valuable information, identifying possible dimensional axes around which points may be arranged (Buser, 1989). Scrutiny of the map is undertaken to assess "apparent dimensions of the map, its regions, and the items making up each cluster …to make conceptually informed conjecture about the possible cognitive structure of the concepts for participants as reflected in their sorting strategies" (Kunkel et al. 1995, p. 128). For this seven cluster-map regarding what helped survivors of childhood sexual abuse to heal, examination indicates that one of the underlying dimensions may involve *relationship with self versus relationship with others*. Of the seven clusters, two focus on relationship with self, four focus on relationships with others, and one includes both self and others.

The dimensional axis related to *relationship with self versus relationship with others* can be seen by examining the differences between the top and bottom portions of the concept map. The bottom of the map contains Cluster 1 (Developing Self-Acceptance and New Skills) and Cluster 7 (Maintaining Balance and Moving On). Both of these clusters have the individual survivor and his or her *relationship with self* as the focus. For example, "Confronting my fears", "Learning how to protect myself", "Being comfortable with all my feelings", "Giving myself empowering messages" are statements contained in Cluster 1 and "Maintaining a balanced life", "Participating in spiritual practices or rituals" and "Remembering everything I could about the abuse" are included in Cluster 7. All of these statements reflect a focus on self or personal growth—developing self-acceptance, learning new skills, maintaining balance, and moving on.

Located at the top of the map are Cluster 5 (Sharing of Self), Cluster 4 (Being Validated), Cluster 2 (Connecting with Others) and Cluster 3 (Having a Strong Support System). The statements in these clusters are focused on the survivor being in *relationship with others*. Clusters 5, 4 and 2 comprise the top right quadrant of the map. The items in Cluster 5 move away from the survivor focusing on self and begin to include the survivor "Sharing of Self" by telling his/her story, helping others, and being more open in relationships. It is not surprising that Cluster 5 is partly about self (sharing self) and partly about others (sharing with others) since of the three clusters in this upper right quadrant it is the cluster in closest proximity to the horizontal axis.

Moving a little higher up the map, Cluster 4 includes statements that reflect other people validating, listening to and believing the survivor. The statement "Attending therapy" is about relationships with others since a key ingredient in effective therapy involves being in relationship with a therapist (Asay & Lambert, 1999; Bachelor & Horvath, 1999; Lambert et al, 2004). In this cluster, "Being Validated", the relationships with others are still very survivor-focused, but the emphasis is on what the survivor receives from others rather than on what they reveal to others (Cluster 5) or what they learn for and about self (Cluster 1). Adjacent to Cluster 4 is Cluster 2, a grouping that contains items about connecting with others through various relationships including being inspired by other survivors, educating others about sexual abuse, having someone reach out, and accessing healthcare professionals.

Moving over to the left, but still in the upper region of the map, Cluster 3 is located and it focuses on "Having a Strong Support System". Clearly this grouping concentrates on relationships with others—supportive family members, a strong and supportive partner, and other healthy influences. Pets and financial assistance were seen as part of this support system. One of the items, "Speaking out about the abuse to protect other potential victims" both required a strong support system and involved supporting or helping others.

The final group of statements, Cluster 6, was located in the more central region of the map, on the left hand side. It was nestled between the lower clusters that focused on the survivor's relationship with self and the upper clusters that had themes of the survivor's relationships with others. Appropriately, this cluster ("Stabilizing Self and Establishing Safety") had the highest bridging value and acted as a bridge between the upper and lower regions. Within this cluster, statements related to *self* included ideas such as being kept safe, quitting drugs, and taking medication. However, many of the statements about establishing stability and safety referred to resolving offender-related issues. Many of these statements about offenders were in the upper region of this grouping, closer to the other statements on the map that referred to relationships with others.

In addition to comparing the upper and lower halves of the concept map, examination of the right and left sides can also provide valuable information about another dimensional axis involving *learning and connecting versus achieving stability*. On the right side of the map are clusters that appear to be related to tasks that involve *learning and connecting* such as "Developing Self-Acceptance and New Skills", "Sharing of Self", "Being Validated" and "Connecting with Others". The left side of the map, on the other hand, has clusters that seem to reflect a sense of *achieving stability* such as "Having a Strong Support System", Stabilizing Self and Establishing Safety", and "Maintaining Balance and Moving On".

In addition to these possible dimensional axes, another way to view this map about what helped survivors heal is through a sequential lens that begins at Cluster 1 and moves counter-clockwise around the map. Such a progression could be considered to resemble the healing journey that many survivors travel: First it begins with the development of self-acceptance and new skills (Cluster 1), which is followed by a sharing of one's self (Cluster 5) and subsequent experiences of being validated (Cluster 4). The survivor connects with others (Cluster 2) and develops a strong support system (Cluster 3) which contributes to the ability to stabilize one's self and establish safety (Cluster 6). Ultimately, the journey ends with the ability to maintain balance and move on (Cluster 7).

Question #2: Hindering Impacts

By following the procedures outlined in the previous chapter, 56 survivors of childhood sexual abuse generated 70 statements that represented their experience of factors or events that hindered their healing. These statements became the items used for the MDS and hierarchical cluster analysis which resulted in an eight-cluster map representing survivors' perceptions of hindering events when healing from childhood sexual abuse. For this question, the MDS procedures resulted in a stress value of 0.23 which is considered reasonable and relatively stable.

The final concept map, including the labels chosen for each grouping, is illustrated in Figure 2. This is immediately followed by Table 6, which outlines the statements of each cluster along with the corresponding bridging and rating values. While the map and table offer an effective summary of the findings regarding hindering impacts, a detailed discussion of each cluster and of the overall map follows.

Concept Map for Question #2: What interfered with your healing from the childhood sexual abuse you experienced?

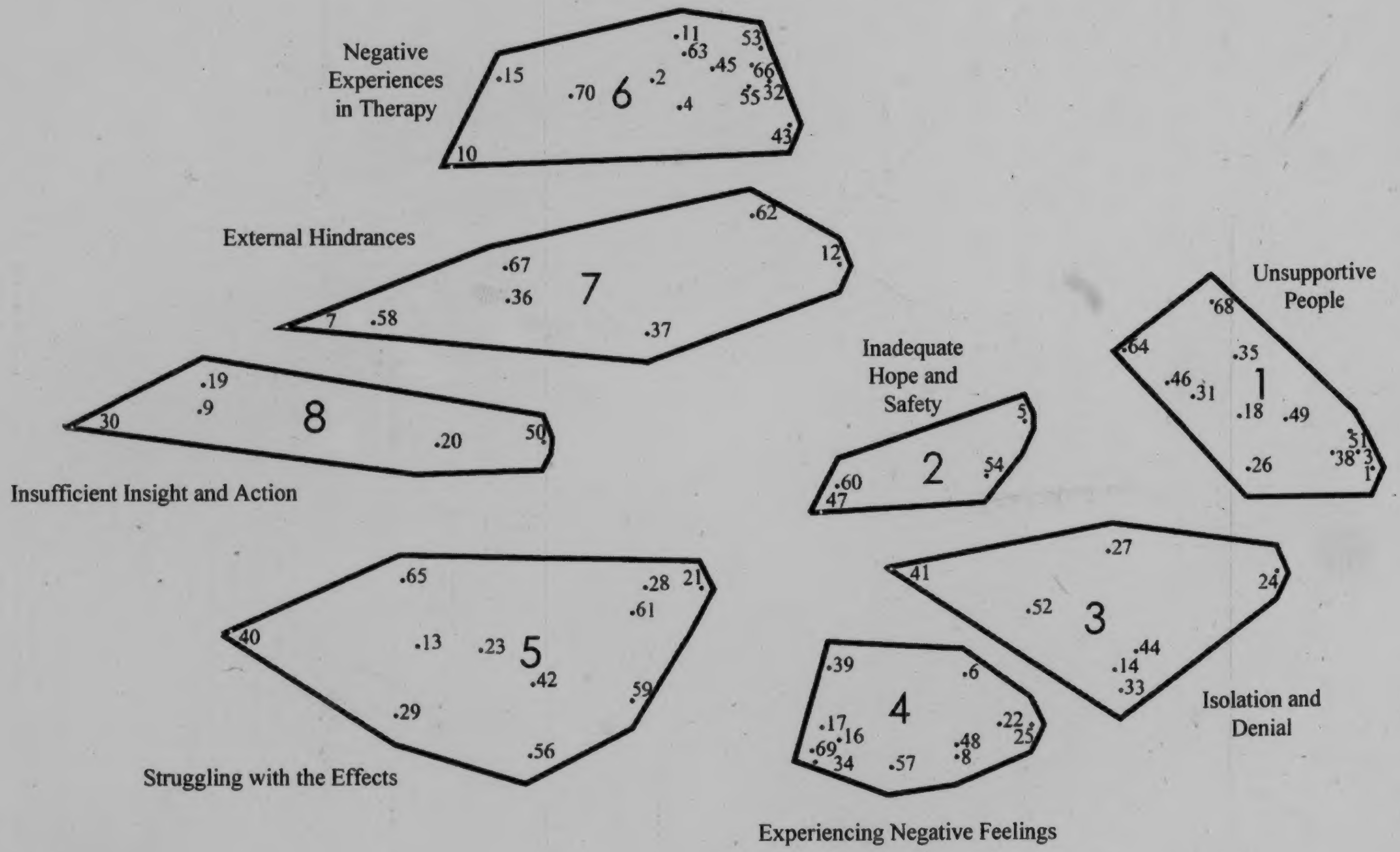
Negative Experiences in Therapy
6
.15 .70 .2 .11 .63 .45 53 66 .4 55 32 43 10
External Hindrances
7
.62 12 .67 .36 .37 7 .58
Insufficient Insight and Action
8
.19 .9 30 .20 50
Struggling with the Effects
5
.65 .28 21 .61 40 .13 .23 .42 59 .29 .56
Inadequate Hope and Safety
2
5 54 .60 47
Unsupportive People
1
68 64 .35 .46 .31 .18 .49 51 38 3 1 .26
Isolation and Denial
3
.27 41 24 .52 .44 .14 .33
Experiencing Negative Feelings
4
.39 .6 .17 .16 .69 34 .22 25 .48 8 .57

Figure 2. Concept map of hindering impacts to healing from CSA

Table 6. Clusters and Items from Survivors' Concept Map of Hindering Impacts

CLUSTER and ITEM	BRIDGING VALUE	RATING VALUE* (mean)
Cluster 1: Unsupportive People	**0.33**	**3.28**
31. Other people making insensitive comments.	0.24	3.46
26. Not being believed by others.	0.26	3.58
46. Interacting with people who believed sexual abuse should not be talked about.	0.26	3.35
18. Having other people resent my healing.	0.28	3.08
38. Having contact with people who were unsupportive.	0.32	3.58
64. Being blamed for the negative effects that occurred after I disclosed the abuse.	0.33	2.96
1. Having unsupportive family members.	0.35	3.96
49. Losing relationships with people after I disclosed my abuse.	0.35	2.92
35. Having people support my offender instead of me.	0.36	3.27
51. Being blamed for the abuse occurring.	0.37	3.04
3. Other people ignoring signs that something in my life was wrong.	0.42	4.00
68. Having an unsupportive spouse.	0.42	2.12
Cluster 2: Inadequate Hope and Safety	**0.26**	**3.19**
47. Believing that there was little hope of ever healing from the abuse.	0.24	3.54
60. Avoiding talking about the abuse.	0.26	3.12
54. Having to confront societal myths about childhood sexual abuse.	0.27	3.12
5. Having my safety and/or the safety of my family threatened.	0.28	3.00
Cluster 3: Isolation and Denial	**0.25**	**3.71**
41. Not wanting to believe the abuse happened.	0.19	2.96
14. Believing that no one cared.	0.21	3.88
44. Feeling betrayed.	0.21	4.12
52. Believing that there was nobody I could turn to for help.	0.22	3.62
33. Being unable to trust people.	0.24	3.77
27. Feeling judged.	0.25	4.04
24. Keeping the abuse hidden from people who were important to me.	0.38	3.62
Cluster 4: Experiencing Negative Feelings	**0.13**	**3.82**
57. Being afraid.	0.09	3.85
48. Experiencing feelings of shame.	0.10	4.15
8. Feeling vulnerable.	0.11	3.77
22. Feeling angry.	0.11	3.15
69. Having negative thoughts about myself.	0.11	4.46
16. Feeling stupid.	0.12	3.27
17. Experiencing intense grief.	0.12	3.54
25. Being insecure.	0.14	4.00
34. Not being patient with myself.	0.14	4.20
6. Having to function "normally" while feeling "broken".	0.18	4.04
39. Believing it was my fault that I was sexually abused.	0.19	3.54

Cluster 5: Struggling with the Effects		**0.41**	**3.43**
21.	Remembering the details of the abuse.	0.21	2.31
59.	Having horrible dreams.	0.24	3.69
28.	Dissociating in order to forget the abuse.	0.26	3.54
42.	Being "triggered" or reminded of the abuse.	0.34	3.50
61.	Making poor choices in relationships.	0.37	3.65
56.	Experiencing difficulty with my sexuality.	0.38	3.88
23.	Experiencing periodic life crises.	0.40	3.65
65.	Acting out aspects of my abuse.	0.46	2.54
29.	Having difficulty with sexual relations.	0.51	3.85
13.	Being unable to stop the sexual abuse from happening.	0.62	3.73
40.	Engaging in self-destructive behaviours.	0.73	3.35
Cluster 6: Negative Experiences in Therapy		**0.09**	**1.89**
55.	Being denied my individual experience by my therapist.	0.00	1.38
45.	Having a therapist who did not seem to care about me as a person.	0.01	2.15
11.	Having a therapist who was not trained in how to deal with sexual abuse.	0.02	2.50
63.	Having a therapist who did not follow through on what was said.	0.02	1.69
66.	My therapist not believing me.	0.02	1.23
32.	My therapist treating my symptoms instead of dealing with the sexual abuse.	0.04	2.50
53.	Being sexually abused by my therapist.	0.05	1.15
2.	Attending therapy that was not focused.	0.06	2.88
4.	Having a therapist who had a forceful approach.	0.09	1.96
70.	Being told by a therapist that I would probably never heal.	0.12	1.31
43.	Having a therapist who displayed shock when I told my story.	0.13	1.62
15.	Having therapy sessions that were too short.	0.24	2.62
10.	Being forced into treatment.	0.38	1.58
Cluster 7: External Hindrances		**0.44**	**2.34**
62.	Being misdiagnosed.	0.24	2.15
37.	Experiencing difficulty finding good resources that were appropriate for me.	0.33	3.08
12.	Having difficulty finding support systems for partners of survivors.	0.34	1.85
36.	Moving frequently.	0.39	2.15
67.	Having limited money to cover the cost of treatment.	0.52	2.96
7.	Lacking an education.	0.60	1.69
58.	Continuing to have contact with my offender.	0.65	2.50
Cluster 8: Insufficient Insight and Action		**0.7[illegible]**	**2.37**
50.	Having no memory of being sexually abused.	0.38	2.19
20.	Growing up with a negative view of spirituality.	0[illegible]	2.23
9.	Not being able to forgive my offender.	0.75	2.42
19.	My offender denying that the abuse occurred.	0.82	2.27
30.	Not seeking counselling.	1.00	2.73

*Note: Participants rated how interfering each item was in healing from the abuse they experienced by using a 5-point scale ranging from 1 (not at all interfering) to 5 (extremely interfering).

Description of Clusters

For this map regarding hindering impacts to healing, it is difficult to determine the dimensional axes partly because many of the clusters are grouped around the axes and in close proximity to one another. The vertical axis, the more obvious of the two, divides the map so that Clusters 5 through 8 are located on the left of it and Clusters 1 through 4 are on its right. The horizontal axis appears to make a less equal division with Clusters 1, 2, 6, 7 and 8 landing above it while Clusters 3, 4 and 5 are located below it. Each of the eight clusters is highlighted below.

Cluster 1: Unsupportive People. Cluster 1 lies the furthest to the right of all the clusters on the map and it is located in the upper right quadrant, very close to the horizontal axis. This cluster received a bridging index of 0.33, suggesting that it represents a cohesive group of ideas. The selection of the label for this grouping, "Unsupportive People", was directly influenced by the participants' language as evidenced by statements within it like, "Having contact with people who were unsupportive", "Having unsupportive family members", "Having people support my offender instead of me" to name just a few. This cluster received an average rating of 3.28, indicating that the items with in it were, on average, experienced as "somewhat" to "pretty interfering".

Cluster 2: Inadequate Hope and Safety. Also located in the upper right quadrant, Cluster 2 is located more centrally, situated near both the horizontal and vertical axes. This cluster contains the items "Believing that there was little hope of ever healing from the abuse", "Avoiding talking about the abuse", "Having to confront societal myths about childhood sexual abuse" and "Having my safety and/or the safety of my family threatened". Overall, these items reflect there being an absence of hope and no sense of safety. The statement regarding societal myths does not fit as well into this grouping; however, it is related since societal myths often contribute to a sense of hopelessness. This cluster had an average bridging value of 0.26, suggesting that the items with it were sorted together with some consistency. Its mean rating value was 3.19, signifying these items represented events that were, on average, rated as "somewhat interfering".

Cluster 3: Isolation and Denial. This cluster lies near Cluster 2, but slightly below it and, as a result, falls into the lower right quadrant on the map. Considerable debate had focused on whether to combine Cluster 2 and Cluster 3, however, the emergence of additional qualitative themes supported the decision to allow them to remain separate. This cluster, “Isolation and Denial”, had a reasonable bridging index (0.25), indicating that the items within it were conceptually similar. This similarity is evident in the statements “Believing that no one cared”, “Believing that there was nobody I could turn to for help”, and “Being unable to trust people”. In addition, this grouping had the second highest average rating value (3.71), indicating that the cluster neared a rating of pretty interfering. The item “Not wanting to believe the abuse happened” (2.96) was assessed as less interfering than items such as “Feeling betrayed” (4.12) and “Feeling judged” (4.04).

Cluster 4: Experiencing Negative Feelings. This cluster received the second lowest bridging index (0.13), indicating that the items within it were frequently sorted together and likely represent a coherent theme. Residing in the lower right quadrant, this cluster is adjacent to the previously described grouping of “Isolation and Denial”. This close proximity is not surprising given the similarity of focus on negative feelings.

The average rating for this cluster (3.82) was the highest of all the groupings on the map, approaching a level corresponding to the description of “pretty interfering”. The items rated as most interfering included “Having negative thoughts about myself” (4.46), “Not being patient with myself” (4.20), and “Experiencing feelings of shame” (4.15). Other statements in this group reflect feelings including being afraid, vulnerable, angry, stupid, and insecure to name only a few. The high rating average, reflecting how interfering the participants experienced the items, may be due in part to the frequency with which these items were endorsed rather than solely a reflection of what impact they had. It is likely that most of the items in this cluster—Experiencing Negative Feelings—were experienced and therefore endorsed by all or most participants. Thus, the fact that this cluster has the highest average rating may be more related to the universal nature of the items within it than to the degree of impact the experiences have when compared to other items or clusters. That is not to say that the items in this cluster were not experienced as significantly negative or interfering. It is simply a caution against over-interpreting or assigning too much importance to the rating value received.

Cluster 5: Struggling with the Effects. Along the bottom of the map, Cluster 5 is the sole occupant of the lower left hand quadrant. This cluster had an average rating of 3.43, suggesting that participants endorsed it as containing items that were "somewhat" to "pretty interfering".

For this cluster, the bridging index is relatively high (0.41) and therefore, when attempting to discern the conceptual theme, emphasis was placed first on the items within the cluster that had the lowest bridging value. Then, items with higher values were considered. Thus, the statements given primary consideration included "Remembering the details of the abuse" (0.21), "Having horrible dreams" (0.24), and "Dissociating in order to forget the abuse" (0.26). Then, statements with slightly higher bridging values were considered as to how they related or fit within an all-encompassing theme: "Being triggered or reminded of the abuse" (0.34), "Making poor choices in relationships" (0.37), and "Experiencing difficulty with my sexuality" (0.38). The central concept of this cluster that began to emerge was the survivor's struggle with the effects of the abuse. With the exception of one statement, the remaining items were all related to this label. The only item that did not seem to fit with the theme of dealing with the effects was "Being unable to stop the abuse from happening". The bridging index for this item was fairly high at 0.62, indicating that the location of this item in this cluster is probably more likely due to it acting as a bridge between other statements or other clusters than it is to do with the statements located near it. Likely, this statement was sorted with many different clusters and as a result of the MDS configuration, its placement ended up within this cluster.

Cluster 6: Negative Experiences in Therapy. Located in the upper left quadrant of the map, this cluster has the lowest bridging index (0.09) of all the groupings on the map, pointing to the similarity of the items within it. Every item within this cluster was related to negative therapy experiences that had interfered with healing for the participants. A few of the statements within this cluster that clearly illustrate this them include, "Being denied my individual experience by my therapist", "Having a therapist who did not seem to care about me as a person", "Having a therapist who was not trained in how to deal with sexual abuse", "Having a therapist who did not follow through on what was said", and "My therapist not believing me".

This cluster had the lowest average rating value (1.89) of all the clusters, however, as mentioned previously, this must be interpreted with caution. Many of the items in this cluster relate to very specific, negative events such as "Being sexually abused by my therapist", "My therapist not believing me" and "Being told by my therapist that I would probably never heal". It is likely that the low cluster rating value is more a reflection of lack of experience or occurrence than of the items lacking a hindering impact when they do occur.

Cluster 7: External Hindrances. Located in the upper left quadrant of the map, this cluster had a bridging index of 0.44. Items with the lowest bridging values in the cluster include "Being misdiagnosed" (0.24), "Experiencing difficulty finding good resources that were appropriate for me" (0.33), "Having difficulty finding support systems for partners of survivors" (0.34), and "Moving frequently" (0.39). These statements seem to suggest events or impacts that are external to the survivor, not necessarily within his or her control.

Statements in this cluster with higher bridging items include "Having limited money to cover the cost of treatment" (0.52), "Lacking an education" (0.60), and "Continuing to have contact with my offender" (0.65). These statements were likely sorted into many other groups or clusters and do not necessarily fit best within this current cluster. Despite their high bridging values, these statements do seem to reflect interfering impacts or hindrances that are external to the survivor. However, support for the idea that this grouping is a bridging cluster can be found by considering its individual items and examining its location on the map. This cluster, "External Hindrances", is located directly beneath the well-defined and internally consistent cluster "Negative Experiences in Therapy". This close proximity is not surprising since this cluster contains several items that are related to difficulties with the mechanics of therapy (e.g., misdiagnosis, lack of resources, limited money for treatment) but not necessarily to the experience of therapy.

Overall, this cluster had an average rating of 2.34, corresponding to the experiences being rated as "slightly interfering" to "somewhat interfering". Within this cluster, the item rated as most hindering by the survivors was "Experiencing difficulty finding good resources that were appropriate for me" (3.08). The statements with the lowest rating within the cluster were "Lacking an education" (1.69) and "Having difficulty finding support systems for partners of survivors" (1.85).

Cluster #8: Insufficient Insight and Action. The final grouping, Cluster 8, is located with two other clusters in the upper left quadrant and it is positioned near the horizontal axis. The average rating value for this cluster (2.37) corresponded with descriptions of "slightly interfering" to "somewhat interfering" to healing.

Cluster 8 has the highest bridging index (0.70) and individual items appeared diverse and had bridging indices ranging from 0.38 to 1.00. The statements with the lowest indices seem to reflect a lack of insight or knowledge and were focused on when labelling this cluster: "Having no memory of being sexually abused" (0.38), "Growing up with a negative view of spirituality" (0.54), and "Not being able to forgive my offender" (0.75). One item refers to insufficient action on the part of the offender or the survivor—"My offender denying that the abuse occurred" (0.82). The final item, "Not seeking counselling", has a bridging index of 1.0 which implies that it may have been sorted with every possible cluster and that its placement within this group is likely due to its role as a bridging item.

Overview of Map

Examination of the map suggests several interesting overall patterns. As indicated previously, the map can be divided by a vertical axis that places Clusters 5 through 8 on the left side and Clusters 1 through 4 on the right half. It seems that the clusters on the left side of the map—"Struggling with the Effects", "Negative Experiences in Therapy", "External Hindrances", and "Insufficient Insight and Action"—have a *behavioural* focus. For the most part, the items in these clusters include things that the survivor did or experienced including remembering details of the abuse, making poor choices in relationships, being sexually abused by a therapist, being misdiagnosed, moving frequently, and not remembering the abuse. The right side of the map, on the other hand, appears to involve a more emotional or *feeling* based focus with the clusters "Unsupportive People", "Inadequate Hope and Safety", Isolation and Denial" and "Experiencing Negative Feelings".

The horizontal axis separates Clusters 3 through 5 on the bottom half of the map from Clusters 1, 2, 6, 7 and 8 on the top half. The lower clusters seem to be related to *individual* elements of experience—"Isolation and Denial", "Experiencing Negative Feelings", and "Struggling with the Effects" of the abuse. In contrast, the upper half of the map includes clusters that seem to represent *interpersonal* aspects that interfered with healing. This interpersonal theme is clear in the clusters "Unsupportive People" and "Negative

Experiences in Therapy" because those clusters are very relationship based. In the other clusters, while not every statement supports this division, many of the items do reflect this interpersonal theme. For example, in the cluster "External Hindrances" items that support this interpersonal focus include the statements about having difficulty finding resources, being misdiagnosed by professionals, and having contact with offenders. The items with an interpersonal dimension in the cluster "Inadequate Hope and Safety" include statements about having safety threatened [by others], avoiding talking about the abuse [with others], and confronting societal issues. The final cluster, "Insufficient Insight and Action" has interpersonal dimension reflected most clearly in its items related to the offender (i.e., "Not being able to forgive my offender" and "My offender denying the abuse").

By examining these apparent dimensions of *individual versus interpersonal* and *feelings versus behaviours* further, each quadrant of the map can be investigated. Based on these dimensional attributes, it would be expected that the upper left quadrant would include clusters about *behaviours* in *interpersonal* situations. As predicted, in this area of the map, reside the clusters regarding "Negative Experiences in Therapy" (e.g., being denied experience by therapist, therapist not believing, being sexually abused by therapist), "External Hindrances" (e.g., difficulty finding resources, being misdiagnosed by professionals, and having contact with one's offender) and "Insufficient Insight or Action" (e.g., inability to forgive offender and offender denying the abuse). All three of these clusters address behaviours in interpersonal relationships.

Moving along the top of the map to the upper right quadrant, clusters related to *feelings* in *interpersonal* situations would be anticipated. In this region, the emotional and interpersonal themes are evident in the cluster label "Unsupportive People". However, the cluster "Inadequate Hope and Safety" requires identifying items within it that have this emotional and interpersonal focus such as statements about having safety threatened [by others], avoiding talking about the abuse [with others], and confronting societal issues. Moving down the map, the lower right quadrant shifts its focus to *feelings* related to the *individual* and is clearly represented by two clusters "Isolation and Denial" and "Experiencing Negative Feelings". Then, shifting to the left results in an examination of the lower left quadrant where the focus is on *behaviours* of the *individual*. Within this region, the only cluster is "Struggling with the Effects" and it includes a listing of many of the behaviours that are problematic for the survivor such as remembering details, having horrible dreams, dissociating, being triggered and making poor choices to name a few. Interestingly, the item "Being unable to stop the sexual abuse from happening" had been pointed out as not fitting well with the cluster label of "Struggling with the Effects". Nonetheless, this item does correspond well to the dimensions of *individual* and *behavioural*.

Question #3: Helpful Therapy Impacts

By following the procedures previously outlined, 56 survivors generated 69 statements that described helpful aspects of the therapy they attended. These statements were sorted and rated by participants and then analyzed using MDS and hierarchical cluster analysis, resulting in a cluster map with a stress value of 0.18, a value that is considered stable.

It was decided that the seven-cluster solution was the most accurate representation of the helpful aspects of therapy as described by survivors of childhood sexual abuse. The final concept map is illustrated in Figure 3 and is immediately followed by a table summarizing each cluster (see Table 7). In addition, each cluster is discussed in further detail and dimensional patterns of the concept map as a whole are considered.

Concept Map for Question #3: In therapy, what helped you heal from the childhood sexual abuse you experienced?

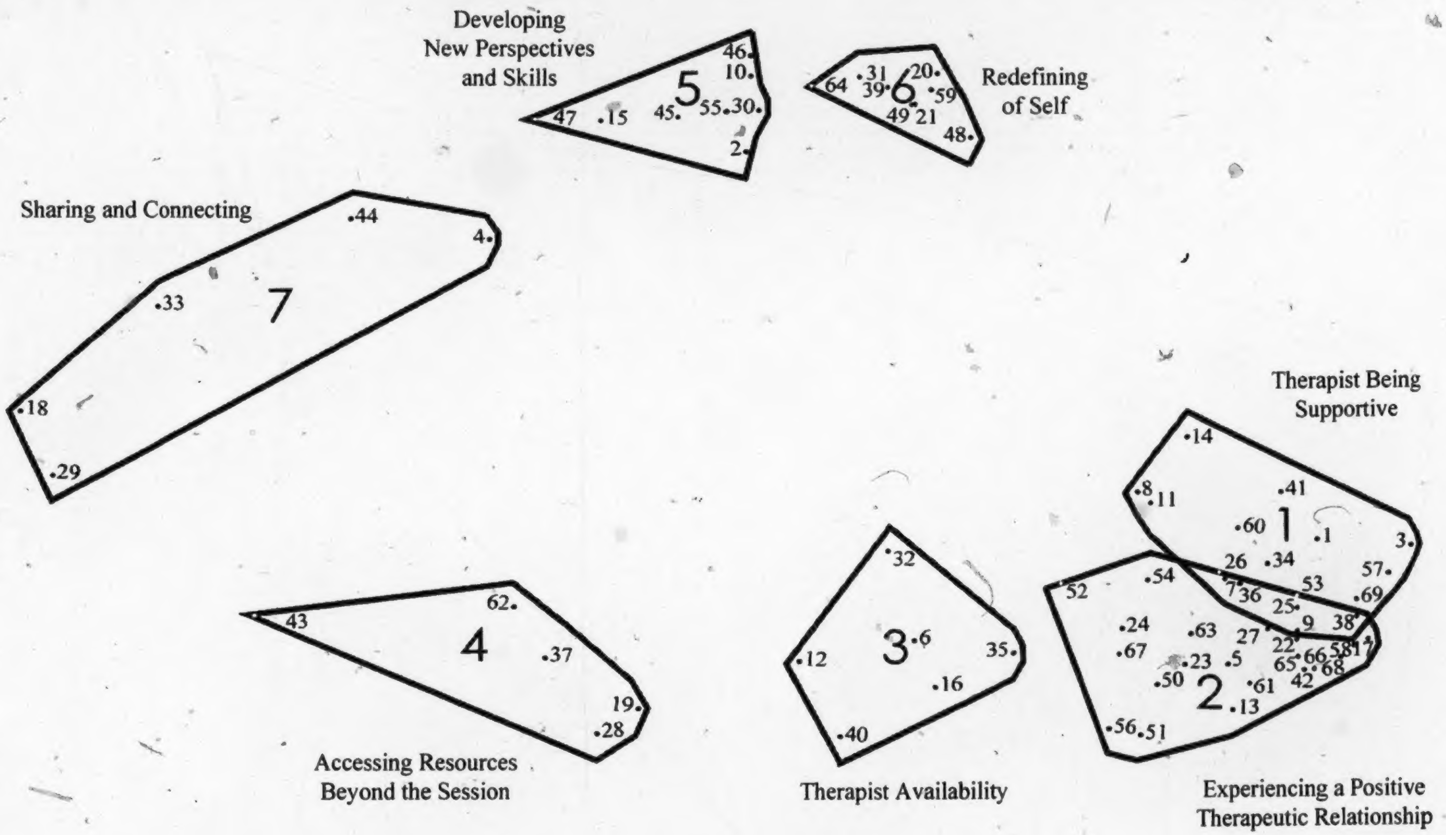
Developing
New Perspectives
and Skills
5
47
15
45
55
30
46
10
2
6
64
31
39
20
59
49
21
48
Redefining
of Self
Sharing and Connecting
7
44
4
33
18
29
Therapist Being
Supportive
1
14
8
11
41
60
1
3
26
34
57
53
69
7
36
25
9
38
2
52
54
24
67
63
27
22
23
5
66
58
17
65
68
42
50
61
13
56
51
Experiencing a Positive
Therapeutic Relationship
4
43
62
37
19
28
Accessing Resources
Beyond the Session
3
32
6
12
35
16
40
Therapist Availability

Figure 3. Concept map of helpful therapy impacts when healing from CSA

Table 7. Clusters and Items from Survivors' Concept Map of Therapy Impacts

CLUSTER and ITEM	BRIDGING VALUE	RATING VALUE* (mean)
Cluster 1: Therapist Being Supportive	**0.11**	**4.26**
25. Being encouraged by my therapist.	0.01	4.67
7. My therapist helping me to see things from a different point of view.	0.03	4.11
36. My therapist helping me to grieve.	0.04	3.67
53. My therapist focusing on my needs.	0.04	4.67
26. My therapist helping to put things in perspective.	0.05	4.41
38. Forming a bond with my therapist.	0.07	4.44
34. My therapist being a "sounding board".	0.08	4.07
69. Having a therapist who listened.	0.08	4.85
57. Being validated by my therapist.	0.12	4.67
60. Believing in my therapist.	0.12	4.22
1. My therapist reminding me that I was safe.	0.13	3.30
11. Being believed when I disclosed my abuse to my therapist.	0.17	4.44
41. My therapist convincing me that I had no reason to be ashamed.	0.18	3.85
8. Being allowed to go at my own pace in therapy.	0.19	4.30
3. Being able to relate to my therapist.	0.22	4.44
14. Learning how to trust my therapist.	0.26	4.04
Cluster 2: Experiencing a Positive Therapeutic Relationship	**0.05**	**4.34**
27. My therapist treating me with respect.	0.00	4.89
65. Having a therapist who understood.	0.00	4.41
22. My therapist being objective.	0.01	4.11
5. Having a therapist who was not judgmental.	0.02	4.74
23. Having a therapist who was knowledgeable about sexual abuse.	0.02	4.37
42. Having a therapist who accepted me.	0.02	4.56
68. Knowing my therapist is concerned about my well-being.	0.02	4.63
9. Having a therapist who earned my respect.	0.03	4.59
58. Having a therapist who cared.	0.03	4.78
61. Having a therapist who was flexible.	0.03	4.26
17. My therapist being patient.	0.04	4.52
63. Having my therapist point out my negative self-talk.	0.04	3.89
66. My therapist expressing confidence in my ability to heal.	0.06	4.52
24. Having a therapist who waited for me to finish what I was saying.	0.07	4.56
50. Developing a long-term relationship with my therapist.	0.07	4.15
67. Being given choices by my therapist.	0.07	3.70
13. My therapist being willing to confront me.	0.08	3.89
54. Having a therapist who never gave up on me.	0.08	4.44
56. My therapist behaving in a professional manner.	0.09	4.44
51. Having a therapist with similar beliefs.	0.12	3.70
52. Being able to talk about any misunderstandings with my therapist.	0.13	3.89

Cluster 3: Therapist Availability		**0.26**	**3.29**
35.	Having my therapist share personal information.	0.16	2.96
6.	My therapist encouraging artistic ways for me to get in touch with my feelings.	0.23	3.37
16.	Having regular therapy appointments.	0.23	4.41
32.	Setting goals with my therapist.	0.27	3.15
40.	Having a therapist who was accessible by phone.	0.31	2.93
12.	My therapist ensuring I have someone to turn to when my therapist is unavailable.	0.34	2.93
Cluster 4: Accessing Resources Beyond the Session		**0.60**	**2.96**
19.	My therapist referring me for complementary health services.	0.48	2.26
28.	Having access to affordable therapy.	0.53	3.85
37.	Reading books suggested by my therapist.	0.57	3.11
62.	Doing "homework" assigned by my therapist.	0.59	3.37
43.	Being able to attend counselling in phases.	0.84	2.19
Cluster 5: Developing New Perspectives and Skills		**0.37**	**3.71**
46.	Learning how to connect to my body.	0.31	3.78
10.	Recognizing that the effects I experienced from having been sexually abused were normal.	0.34	4.07
30.	Being able to recall memories.	0.34	3.78
55.	Learning not to compare myself to others.	0.35	3.48
45.	Dealing with my own denial about the sexual abuse.	0.36	3.22
2.	Having opportunities to change my beliefs about the abuse.	0.38	3.67
15.	Being taught assertiveness skills.	0.42	3.52
47.	Realizing that I was not alone.	0.48	4.15
Cluster 6: Redefining of Self		**0.33**	**4.05**
21.	Recognizing my self-worth.	0.30	4.07
31.	Learning to cope with the effects of the sexual abuse.	0.30	4.33
39.	Gaining an understanding of my feelings about the sexual abuse.	0.30	4.30
20.	Learning to ask for what I need.	0.33	3.74
49.	Re-examining my childhood experiences.	0.33	4.30
59.	Learning not to blame myself for the sexual abuse.	0.33	3.96
64.	Learning to express my feelings.	0.33	3.96
48.	Learning to trust people.	0.41	3.70
Cluster 7: Sharing and Connecting		**0.84**	**3.50**
4.	Telling my story.	0.61	4.37
44.	Doing journaling.	0.68	3.63
18.	Connecting with other survivors.	0.96	3.30
33.	Having my spirituality included in my healing.	0.96	3.11
29.	Receiving support from others who struggle with similar issues.	1.00	3.11

*Participants rated each item according its helpfulness in therapy focused on overcoming childhood sexual abuse based on their experience. The 5-point scale ranged from 1 (not at all helpful or not applicable) to 5 (extremely helpful).

Description of Clusters

Cluster 1: Therapist Being Supportive. In the bottom right hand quadrant of the map, Cluster 1 (Therapist Being Supportive) overlaps with Cluster 2 (Experiencing a Positive Therapeutic Relationship). Although this overlap is not ideal, Cluster 1 has the second lowest bridging index of all the clusters on the map (0.11), suggesting that it includes statements with a high degree of similarity in terms of the frequency with which these items were sorted together. This low bridging value indicates that it is a discrete cluster that represents a cohesive theme.

As a label, the "Therapist Being Supportive" is a good example of how feedback from five colleagues influenced decisions regarding the theme or label for the cluster. Although, the researcher had initially identified this cluster as "Therapist Interventions", feedback from colleagues suggested that "Therapist Being Supportive" would be more representative of the participants' experiences and was therefore incorporated.

This cluster was rated as the second most helpful grouping on the map (4.26), assessed as falling between "pretty helpful" and "extremely helpful". The item with the highest average rating was "Having a therapist who listened" (4.85) and three statements (25, 53, 57) had tied ratings of 4.67 as the next most helpful: "Being encouraged by my therapist", "My therapist focusing on my needs", and "Being validated by my therapist". This cluster and the items within it reveal that while it is important that the therapist provides guidance, it is equally important that the guidance be respectful, supportive, validating, and focused on the survivor's needs.

Cluster 2: Experiencing a Positive Therapeutic Relationship. Having the lowest average bridging index (0.05) and the highest average rating (4.34), not only did the statements in this cluster get sorted together frequently, but they also were rated as the most helpful. The three statements endorsed as most helpful were "My therapist treating me with respect" (4.89), "Having a therapist who cared" (4.78), and "Having a therapist who was not judgemental" (4.74). Cluster 2 is the largest grouping of items, with 21 statements comprising the theme of "Experiencing a Positive Therapeutic Relationship".

At first glance, it seems that there are several smaller groupings or themes within this cluster. For example, many of the statements, particularly the ones with the lowest bridging values, address *positive therapist attitude* such as being understanding, objective, non-judgemental, accepting, concerned, caring, flexible and patient to name just a few. Then, there are items that seem to represent *therapist interventions and actions* such as pointing out negative self-talk, giving choices, confronting, never giving up, and behaving professionally. Then, a third collection of statements seems to reflect the idea of *mutuality in the therapeutic relationship.* This mutuality is heard in items that refer to "earned respect", "developing a long-term relationship", "similar beliefs", and the ability to "talk about misunderstandings". Although these themes seem to emerge within the cluster, attempts to further divide this cluster result in fragmented collections of overlapping ideas. The cluster does not divide according to these themes and it does not appear to divide in a manner that allows other themes to emerge. Thus, while Cluster 2 has distinct themes within it, these themes only emerge as sub-themes within the broader context of "Experiencing a Positive Therapeutic Relationship". Once again, recall that this grouping as a whole is the most cohesiveness of all the clusters on the map according to its bridging index (0.05) despite the fact that it is large, contains sub-themes and overlaps with another cluster.

Cluster 3: Therapist Availability. Along with the first two clusters described, Cluster 3 is located in the bottom right quadrant of the concept map, situated close to the vertical axis. With the third lowest bridging index (0.26), this cluster represents a relatively cohesive grouping of items. Cluster 3 has the second lowest rating of all the clusters (3.29), falling in the "somewhat helpful" to "pretty helpful" range. Within this cluster, one item was rated notably higher—"Having regular therapy appointments" (4.41)—suggesting that it was experienced as the most helpful item in this cluster.

Therapist availability is reflected in cluster items such as "Having a therapist who was accessible by phone" (Statement 40), "Having regular therapy appointments" (Statement 16), and "My therapist ensuring I have someone to turn to when my therapist is unavailable" (Statement 12). Within this cluster, therapist availability can also reflect an emotional openness or availability as in Statement 35, "Having my therapist share personal information".

Cluster 4: Accessing Resources Beyond the Session. Cluster 4, located in the bottom left quadrant of the map, has the second highest bridging index (0.60), indicating that these items were sorted with many of the other groups and that their location on the map may be a result of the items being a bridge between two or more clusters to which it was related. This is particularly true for the statement "Being able to attend counselling in phases" (Statement 43) which had a bridging index of 0.84. The location of this item within this cluster is most likely to do the frequency with which it was sorted with a variety of clusters. A visual inspection of the points on the map demonstrates that while the other four items in this cluster are grouped in relative close proximity to one another, this statement (43) is positioned much further to the left, reflecting that it is not as similar to the items with which it is grouped.

The remaining statements in this cluster, although their bridging values are moderately high, seem to be similar to each other in that the statements describe activities that are related to therapy but occur outside of therapy. For example, "My therapist referring me for complementary health services" (Statement 19), "Reading books suggested by my therapist" (Statement 37), and "Doing homework assigned by my therapist" (Statement 62) all relate to activities the client learns about from the therapist but engages in outside of the therapy sessions. The item "Having access to affordable therapy" (Statement 28) refers to being able to access resources external to the therapy session (i.e., financial support or affordable programs) in order to attend therapy.

This cluster, "Accessing Resources Beyond the Session", had the lowest average rating of all the clusters on the map. With an average of 2.96, the helpfulness rating fell between "slightly helpful" and "somewhat helpful". Within the cluster, the item "Having access to affordable therapy" was identified as most valuable (3.85).

Cluster 5: Developing New Perspectives and Skills. Examination of the upper left quadrant of the map reveals Cluster 5, which focuses on the insight or new perspectives gained and the skills learned in therapy. With a bridging index of 0.37, this cluster had the third highest value. Its rating average of 3.71 indicated that, on average, survivors considered the items with in it "somewhat helpful" to "pretty helpful". Within this cluster, the two statements rated the highest in terms of helpfulness were "Realizing that I was not alone" (4.15, Statement 47) and "Recognizing that the effects I experienced from having been sexually abused were normal" (4.07, Statement 10). Other support for the idea of understanding or perspective being gained included the items related to dealing with denial and having opportunities to change beliefs about the abuse (Statements 45 and 2). The "new skills" referred to by the cluster label included "Being taught assertiveness skills" (Statement 15) and "Learning how to connect to my body" (Statement 46). The remaining statement, "Being able to recall memories" (Statement 30) reflects both a new perspective and a skill to some degree—the recalling of memories is a skill or ability learned that had not happened previously, but "being able to" remember would change or influences one's perspective or how things are viewed.

Cluster 6: Redefining of Self. Cluster 6 is in close proximity to Cluster 5, yet located in the upper right quadrant of the concept map. As previously discussed, considerable debate focused on whether or not this cluster should be grouped with Cluster 5, thereby resulting in a six-cluster map rather than the seven-cluster one that was selected. Although many items in this cluster resemble the "new skills and perspectives" referred to in Cluster 5, the items in this cluster seem to suggest more profound changes of self as opposed to the insight-oriented or behavioural statements evident in the previous cluster. For example, "Recognizing my self-worth" and "Learning to trust people" (Cluster 6, Statements 21 and 48) seem qualitatively different than "Realizing I was not alone" and "Being taught assertiveness skills" (Cluster 5, Statements 47 and 15). The statements in Cluster 6 imply more than just behavioural changes or shifts in perspective. Rather, they seemed to reflect a shift of how a person views him/herself and the world in which he or she lives.

The statements in this cluster involve learning to trust, to express feelings, and to ask for what one needs. It is not simply about "recognizing the effects" (Cluster 5, Statement 10), but it is also about "learning to cope with the effects" and "learning to express my feelings" (Cluster 6, Statements 31 and 64). Thus, although Cluster 6 ("Redefining of Self") is related to Cluster 5 ("Developing New Perspectives and Skills"), this similarity is expected to some degree since they are in close proximity on the concept map. Overall, though, it seemed that the two clusters were qualitatively different, with Cluster 6 referring to changes that involved a "Redefining of Self". When compared to Cluster 5, Cluster 6 had a slightly lower bridging index (0.33 vs. 0.37) as well as higher average cluster rating (4.05 vs. 3.71). This indicated that it was a somewhat cohesive group of statements that were viewed as "pretty helpful" to "extremely helpful".

Cluster 7: Sharing and Connecting. The final cluster of this concept map, "Sharing and Connecting", is located in the upper left quadrant. In terms of the helpfulness of these items to survivors, the cluster as a whole was rated as being between "somewhat helpful" and "pretty helpful" (3.50). "Telling my story" (Statement 4) was the only item for which the rating began to approach the level of "extremely helpful" (4.37). With a collective voice, survivors seem to be saying, one of the aspects of therapy that is helpful is that it provides a place to have their story heard.

The average bridging index for this cluster is quite high (0.84) suggesting that its location on the map was due to it acting as a bridge between other clusters or items on the map. More specifically, three of the statements within this cluster have bridging indices approaching or reaching one: "Connecting with other survivors" (0.96, Statement 18), "Having my spirituality included in my healing" (0.96, Statement 33) and "Receiving support from others who struggle with similar issues" (1.0, Statement 29). Ratings this high indicates that these statements could have potentially been sorted with every cluster and were not sorted in any consistent manner. Although not quite as high, the remaining two items in this cluster also have considerably high bridging values: "Telling my story" (0.84, Statement 4) and "Doing journaling" (0.68, Statement 44).

Although the bridging values for the individual items in this cluster are very high, each statement relates well to the theme of "Sharing and Connecting". Telling one's story and journaling (Statements 4 and 44) involve a sharing of self with others, connecting with others in these unique ways. In addition, "Receiving support from others who struggle with similar issues" (Statement 29) and "Connecting with other survivors" (Statement 18) are clearly encompassed within this theme, with the language from the latter statement being incorporated into the cluster label. Perhaps the inclusion of the item "Having my spirituality included in my healing" (Statement 33) is less clear. When one considers, however, that spirituality usually involves connecting a person to someone or something bigger than self (e.g., God, nature) then the fit of this item to the theme of "Sharing and Connecting" becomes more apparent.

Overview of Map

An inspection of the concept map as a whole reveals several interesting patterns. On the bottom half of the map, the four clusters are *therapy-focused*—Therapist Being Supportive, Experiencing a Positive Therapeutic Relationship, Therapist Availability, and Accessing Resources Beyond the Session. On the other hand, the three clusters on the top half of the map are *client-focused*—Developing New Perspectives and Skills, Redefining of Self, and Sharing and Connecting—describing things the client learns, experiences, or does. Interestingly, Cluster 7 (Sharing and Connecting) is located primarily in the upper half of the map, which is related to having a client-focus. However, this cluster has a lower point containing two statements reaching toward the bottom half of the map—"Connecting with other survivors" (Statement 18) and "Receiving support from others who struggle with similar issues" (Statement 29). It seems appropriate that these statements would be located closer to the therapy section of the map since they have the element of "group therapy" implied within them. The other items in this cluster have statements much more associated with the client—telling one's story, journaling, and connecting to their spirituality (Statements 4, 44 and 33) and these items are located more definitively in the upper half of the map. As mentioned previously, this cluster has a very high bridging value (0.84) indicating that the placement on the map of the individual items is influenced by the items being bridges between other items and by the items not being sorted in any consistent manner.

As the concept map is inspected from left to right, there appears to be a shift from *behaving* to *feeling*. For example, on the left side of the map, the clusters reflect actions of the survivor or client— Sharing and Connecting (Cluster 7), Accessing Resources Beyond the Session (Cluster 4), and Developing New Perspectives and Skills (Cluster 5). The right side of the map, on the other hand, contains groupings that focus more on *feelings* or an emotional component such as the Therapist Being Supportive (Cluster 1) and Experiencing a Positive Therapeutic Relationship (Cluster 2). The remaining two clusters on the right side of the map (Clusters 6 and 3) are located very close to the vertical axis and as such their reflection of the *feeling* dimension begins to weaken (but is still present) and the *behaviour* dimension begins to strengthen (but is not yet the main theme).

Based on their cluster labels, Cluster 6 and 3 do not appear as directly related to the theme of *feelings*; however, closer inspection of the items within each grouping confirms that this *behaviour versus feeling* dimension is supported. For example, in Cluster 6 ("Redefining of Self") some of the statements that reflect this *feeling* dimension include "Recognizing my self-worth" (21), "Gaining an understanding of my feelings about the sexual abuse" (39), "Learning not to blame myself" (59), and "Learning to trust people"

(48). In Cluster 3, "Therapist Availability", the emotional dimension is directly present in statements like "My therapist encouraging artistic ways for me to get in touch with my feelings" (Statement 6) but is more indirect in other statements. Many of the remaining statements refer to the therapist being available (e.g., regular appointments, back-up when away, accessible by phone, and self-disclosure) and availability can have tremendous impact on the emotional climate, in particular on the client's sense of safety. In this way, this cluster is seen as supporting the dimensional aspect of behaving *versus* feeling, particularly since this cluster is located close to the vertical axis.

Dividing the map along these two continuums—*therapist-focused versus client-focused* and *behaving versus feeling*—gains additional support from an examination of the resulting quadrants. According to these global map themes, the lower right quadrant of the map represents *therapy-focused* and *feeling* themes. In this quadrant are the clusters of "Therapist Being Supportive", "Experiencing a Positive Therapeutic Relationship", "Therapist Availability"—all clusters with a therapy or therapist focus and all clusters with an emotional or feeling theme. Moving up on the map, the top right groupings include *client-focused* and *feeling* themes. Not surprisingly, this is where "Redefining of Self" is located—a cluster focused on the client recognizing his/her self-worth, learning to express feelings, and learning to trust others to highlight just a few of the consistent items within this quadrant.

Moving across the map to the top left quadrant, themes should continue to have a *client-focus* with items focused on *behaving* rather than feeling. It is within this quadrant that the clusters related to "Developing New Perspectives and Skills" (Cluster 5) and "Sharing and Connecting" (Cluster 7) are located. Both of these clusters focus on client behaviours and thus continue to support the identified map dimensions. The final quadrant, in the lower left side of the map, should include groupings related to *behaviours* with a *therapy* focus rather than with a client focus. Cluster 4, "Accessing Resources Beyond the Session", meets this expectation by containing the items "Being able to attend counselling in phases", "My therapist referring me to complementary health services", and "Doing homework assigned by my therapist".

Whether the concept map is examined item-by-item, cluster-by-cluster, quadrant-by-quadrant, or as one entire map, consistent and important themes emerge. These themes describe, from the perspective of survivors, what aspects of therapy have been helpful in their healing from the childhood sexual abuse they experienced.

Summary

The results of this study include three concept maps which provide a visual representation of the helpful and hindering impacts to healing as experienced and perceived by survivors of childhood sexual abuse. Through these maps a conceptual understanding of helpful impacts, hindering impacts and helpful impacts in therapy from the perspectives of the survivors themselves can be gained.

The first map represents the seven significant concepts or themes that were identified by the survivors as helpful to their healing. The concepts or themes included developing self-acceptance and new skills, connecting with others, having a strong support system, being validated, sharing of one's self, stabilizing oneself and establishing a sense of safety, and maintaining balance and moving on. These helpful impacts seemed to be arranged along two dimensions—*relationship with self versus relationship with others* and *learning and connecting versus achieving stability*.

With regard to hindering impacts to healing, the second concept map provides a visual representation of eight themes identified by the survivors as hindering or interfering. These themes included interacting with unsupportive people, having inadequate hope and safety, feeling isolated and being in denial, experiencing negative feelings, struggling with the effects, having negative experiences in therapy, facing external hindrances, and having insufficient insight and action. The underlying dimensions around which these themes seemed to be organized include *individual versus interpersonal* and *feelings versus behaviours*.

The final concept map focuses on events that were perceived by survivors as helpful within a therapeutic setting. The seven themes that emerged regarding helpful therapy impacts included the therapist being supportive, experiencing a positive therapeutic relationship, the therapist being available and the client being involved, accessing resources beyond the session, developing new perspectives and skills, redefining one's self, and sharing and connecting with others. These helpful therapy impacts seemed to be organized around the dimensional axes of *therapist-focused versus client-focused* and *behaving versus feeling*.

This chapter provided a detailed description of the results of this project that aimed to develop a conceptual understanding of helpful and hindering impacts on healing when overcoming childhood sexual abuse. The next chapter will discuss these findings in further detail.

Chapter 5: Discussion

Motivation for the present study came from a desire to increase our understanding of abuse survivors' perspectives of what is helpful and hindering when healing from childhood sexual abuse. There has been a call for research that incorporates the client's perspective and that is more qualitative and exploratory in nature so that information gathered is not predefined or influenced by researchers' assumptions (Elliott & James, 1989; Paulson et al., 1999). By using concept mapping methodology, an approach that combines qualitative and quantitative strategies, this study was able to focus on the perspectives of survivors in order to identify what they believe has been most helpful and most hindering to their healing. Through an open-ended questionnaire, a purposive sample of survivors shared their experience of healing from childhood sexual abuse. From the participants, statements were generated according to three areas—what helped healing, what interfered with healing, and what about therapy was helpful. Multidimensional scaling and cluster analysis techniques were then conducted to determine possible themes.

Through this process, three concept maps emerged that summarized helpful and hindering influences to healing and, more specifically, helpful influences within therapy as experienced by survivors. The previous chapter described each of these maps in detail. This chapter examines how each map is related to previous research, highlighting new findings throughout the discussion. In addition, limitations of this study, implications for helping survivors and recommendations for future research will be addressed.

Helpful Impacts

The concept map regarding what helped survivors heal from or overcome the childhood sexual abuse they experienced resulted in the identification of two broad themes: relationship with self and relationships with others. Regarding one's relationship with self, the current investigation identifies new findings such as developing self-acceptance and deciding to stop being a victim as central to healing. As well, previous research concerning the helpfulness of developing new skills and achieving stability is supported. Concerning relationships with others, existing research has highlighted the central contribution that supportive relationships make to healing (Armsworth, 1989; Feinauer, 1989; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Malmo & Laidlaw, 1995; Valentine & Feinauer, 1993). However, the current study builds upon the role of relationship with others as important to healing by also identifying the value of internet support groups as one type of supportive relationship and by recognizing the influences of the survivor's relationship with the offender. The findings related to relationship with self and relationships with others will now be examined in further detail.

Relationship with Self

One difference between this study and existing literature is the emphasis that is placed on developing self-acceptance. Developing self-acceptance emerged as an important aspect of healing and was described as involving learning to be one's self, re-examining childhood beliefs, being patient with and forgiving of self, being comfortable with all of one's feelings, confronting fears and reconnecting with feelings, finding strengths that resulted from the abuse, and taking time to care for one's self. Some ideas related to the theme of self-acceptance have been mentioned in previous studies such as the importance of survivors believing in themselves (Valentine & Feinauer, 1993), having inner strengths and beliefs and learning new ways of thinking (Glaister & Abel, 2001) and accepting the abuse as part of one's past, developing insight and working through feelings (Godbey & Hutchinson, 1996). However, it seems that previous research has not emphasized the development of self-acceptance as a unique and important influence on healing. The participants in this study clearly identified that learning to accept themselves helped them to heal from childhood sexual abuse.

Another aspect of how one's relationship with self emerged as an important theme involved participants taking personal responsibility for their healing by making the decision to stop being a victim. While other researchers have addressed the importance of making a decision to heal and being committed to it (Glaister and Abel, 2001), there is little mention of making a conscious decision to stop being a victim. For survivors, it seems that making such a decision was pertinent to their healing.

The current study supports the importance of developing new skills such as assertiveness and coping skills (Glaister & Abel, 2001). Also, there is recognition of the helpfulness of several activities previously identified as healing strategies by Malmo and Laidlaw (1995) such as journaling, taking time to care for one's self, giving one's self empowering or affirming messages, finding creative ways of expression, maintaining balance, remembering the details of the abuse, feeling safe and having a relaxed environment. In addition, there is support for previous findings regarding the importance of stabilizing one's self and achieving stability is seen as including factors such as quitting drug or alcohol use (Godbey & Hutchinson, 1996), being kept safe from self-destructive behaviours (Glaister & Abel, 2001; Godbey & Hutchinson, 1996), and taking medication (Malmo & Laidlaw, 1995).

Relationships with Others

The importance of relationships with others to healing is not surprising given that sexual abuse is a violation that occurs between two or more people, usually in the context of a relationship known to the victim (Finkelhor, 1994; Saunders et al., 1999). According to attachment theory, primary attachments that are formed between a child and his or her caregiver are enduring patterns that become internalized and define a person's expectations of self, others and relationships (Peluso et al., 2004). When abuse occurs within this primary attachment relationship, it is believed to cause an insecure attachment style to form (Alexander, 1992; Swanson & Mallinckrodt, 2001). Even when the primary attachment style is secure, subsequent negative life experiences such as experiencing sexual abuse are believed to be able to change a secure attachment style to an insecure one (Bolen, 2002; Waters et al., 2000). When a person experiences sexual abuse, it can interfere with the ability to learn to trust, to act autonomously and to form stable and secure relationships (Berliner & Elliott, 2002). Healing from childhood sexual abuse involves using subsequent relationships in a "secure" way in order to give new meaning to a person's internalized sense of self, others and relationships (Slade, 1999).

In the current study, the helpfulness of relationships with others includes an emphasis on connecting with others, having a strong support system, being validated by others, and sharing of one's self with others. Connecting with others emphasized support received through self-help programs, support networks, connecting with other survivors, accessing various health care professionals, and being inspired by others who have healed. These influences on healing were strikingly similar to healing factors identified by Malmo and Laidlaw (1995) who had identified strategies such as support networks, support groups, using external resources, and having role-models/mentors as important.

Participants' descriptions related to the importance of having a strong support system continued to emphasize the significance of relationships to healing and had considerable support in existing literature. Factors that were seen as influencing healing included accessing support anonymously (Malmo & Laidlaw, 1995), having supportive family and friends and connecting with people who were supportive (Armsworth, 1989; Feinauer, 1989; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Malmo & Laidlaw, 1995; Valentine & Feinauer, 1993), having a pet (Malmo & Laidlaw, 1995) and educating others about sexual abuse (Malmo & Laidlaw, 1995). Interestingly, in the current study the helpfulness of anonymous support included references to internet support groups, thereby identifying an arena of support that has received little attention in existing literature.

Findings regarding the importance of being validated by others also support the importance of relationships when healing from childhood sexual abuse. Validation referred not only to being validated, but also to being believed, listened to and loved and its relevance had been identified in previous research (Armsworth, 1989). Another way in which relationships were seen as playing a role in healing for both this study and previous ones included the sharing of oneself with others. This sharing of self included telling one's story and disclosing information about the abuse (Feinauer, 1989; Malmo & Laidlaw, 1995), helping other people (Malmo & Laidlaw, 1995), and learning to be open in relationships (Glaister & Abel, 2001; Feinauer, 1989; Godbey & Hutchinson, 1996; Malmo & Laidlaw, 1995; Valentine & Feinauer, 1993).

When examining the contribution of relationships with others to healing, one relationship that deserves special mention is the survivor's relationship with the offender. Some offender-related issues had been previously identified as potentially impacting healing such as confronting the offender (Malmo & Laidlaw, 1995), deciding whether to forgive the offender (Glaister & Abel, 2001) and assigning blame to the offender (Godbey & Hutchinson, 1996). However, the participants in the current study expanded on the importance of offender related issues by highlighting healing influences such as being protected from the offender, never having to see the offender, having the offender admit to the abuse or dealing with the offender's denial, and taking action against the offender. Resolving offender related issues may play a more essential role in healing than has been identified in previous literature.

Hindering Impacts

The issue of hindering events when healing from childhood sexual abuse has rarely been investigated from the perspectives of survivors with one study addressing a variety of factors that interfere with healing (Glaister & Abel, 2001) and two studies examining aspects of therapy that interfere with healing (Armsworth, 1989; Draucker & Petrovic, 1997). Since the literature regarding unhelpful influences on healing for survivors is limited, studies examining hindering experiences for survivors in group counselling (Hall & King, 1997; Palmer et al., 2004) and hindering factors for clients in general (Bowman & Fine, 2000; Paulson et al., 2001) were also examined for insight into hindering aspects of healing. Given the scarcity of research regarding hindering impacts specifically related to survivors of childhood sexual abuse, the current study is noteworthy due to its exploration of hindering impacts to healing that occur both within and outside of therapy.

The current investigation suggests that hindering impacts to healing can be divided according to influences related to the individual survivor, to interpersonal relationships, and to external factors. These three areas will be summarized briefly before being examined in further detail.

Individual factors that hinder healing are consistent with previous findings that describe survivors' own perceptions, feelings and behaviours as interfering with their healing process (Glaister & Abel, 2001; Hall & King, 1997; Palmer et al., 2004). In addition, several individual-related hindering impacts that have received little or no mention in previous research regarding healing from childhood sexual abuse emerged. These new findings include interfering influences such as having little hope of healing, not having specific memories of the abuse, and being unable to forgive the offender.

With regard to interpersonal factors, existing literature has clearly established that unsupportive people interfere with healing from childhood sexual abuse (Armsworth, 1989; Glaister & Abel, 2001). The hindering influence that unsupportive people have on healing is recognized and expanded upon by the current study which more specifically identifies hindering factors that occur after the abuse is disclosed such as being blamed, losing relationships, and not being supported. As well, results are consistent with previous research that suggests that lacking a sense of safety can hinder healing (Glaister & Abel, 2001) Issues related to safety are seen as including being in harmful relationships, dealing with societal views, and avoiding talking about the abuse. In addition, findings are consistent with literature that describes various ways in which the client-therapist relationship can hinder or interfere with healing.

The participants in the current investigation suggested a variety of factors that interfere with healing that seem to be external to the survivor. These external hindrances are rarely mentioned in existing literature and include factors such as being misdiagnosed, lacking resources and money, moving often, lacking an education and maintaining contact with the offender.

Individual-Related Factors

The findings of the current investigation indicate that survivors themselves interfere with their healing as evidenced by themes such as experiencing negative feelings, isolation and denial, and struggling with the effects, thereby providing support for previous literature which suggests that survivors' own perceptions, feelings and behaviours interfere with their healing (Glaister & Abel, 2001). Where participants in the current study reported that negative thoughts about themselves interfered, survivors in the study by Glaister and Abel indicated that self-devaluation interfered. In the current study, survivors suggested that engaging in self-destructive behaviours and making poor choices in relationships interfered much like the survivors in the Glaister and Abel study who indicated that using alcohol and staying in hurtful relationships interfered with healing.

Findings regarding the hindering impact of factors related to the individual also support results of studies that involved survivors who attended group therapy or inpatient treatment programs. For example, experiencing negative feelings such as vulnerability, fear and insecurity were reported as hindering by participants who attended group therapy (Hall & King, 1997; Palmer et al., 2004) and experiencing negative feelings such as feeling vulnerable, afraid and insecure were identified as hindering by participants in the current study. Similarly, being triggered or reminded about the abuse was reported as hindering in previous studies (Hall & King, 1997) as well as in the current one.

A new factor that emerged as interfering with healing for participants involved believing that there was little hope of healing from the abuse. This lack of hope was not mentioned as a hindering factor in previous research regarding survivors of childhood sexual abuse; however, the importance of having hope has been emphasized in the literature on helpful influences to healing, “Most of all they were helped by believing that healing was possible” (Glaister & Abel, 2001, p. 194). It seems that while having hope facilitates healing, not having hope interferes with healing.

Another new finding includes survivors’ lacking insight as reflected by not having specific memories of the childhood sexual abuse. The absence of specific memories of sexual abuse has not been previously identified in the literature as a hindering factor even though it has been recognized that many documented childhood sexual abuse cases are later forgotten or excluded from memory (Finkelhor, 1994). It seems that additional information regarding the impact of forgetting the abuse is necessary in order to understand its impact on healing.

In the present study, as well as in previous research, resolving issues related to forgiving the offender was seen as helpful to healing (Glaister & Abel, 2001; Turell & Thomas, 2001). Similarly, being unable to forgive the offender was found to interfere with healing. Although previous research regarding helpful impacts has suggested that resolving issues related to forgiveness is important, the inability to forgive had not yet been identified as interfering in the limited research that exists regarding hindering impacts to healing.

Interpersonal Factors

As well as survivors interfering with their own healing, the participants in this study identified numerous ways in which relationships with others impeded their healing. Consistent with previous findings, unsupportive people (e.g., family members, spouses, friends and therapists) were believed to interfere with healing by doing things such as making insensitive comments, not believing the survivor, blaming the survivor and ignoring signs that something was wrong (Armsworth, 1989; Glaister & Abel, 2001). The identification of additional ways in which unsupportive people hindered healing emphasized negative impacts that occur after the sexual abuse is disclosed. For example, participants described their healing being hindered by being blamed for the negative effects that occurred after disclosure, by relationships ending after disclosure, and by having other people support the offender instead of the survivor after the abuse was disclosed.

Lacking a sense of safety was considered primarily interpersonal since it referred to having one's personal safety threatened by others, needing to confront myths within society, and avoiding talking with others about the abuse. Previous research supported these themes of harmful relationships, societal issues and avoidance as factors that hindered healing (Glaister & Abel, 2001).

In terms of interpersonal hindering impacts, the ones that have received the most attention in previous literature revolve around the client-therapist relationship and negative experiences in therapy. Participants in the current study describe hindering impacts in therapy similar to those outlined in previous studies: therapists denying survivors' experiences (Armsworth, 1989); uncaring, disbelieving, or negative responses from the therapist (Armsworth, 1989; Draucker & Petrovic, 1997); exploitation or victimization of the client (Armsworth, 1989; Draucker & Petrovic, 1997); therapists who lack knowledge and understanding of abuse issues (Draucker & Petrovic, 1997; Glaister & Abel, 2001), and therapists who are forceful or controlling (Draucker & Petrovic, 1997).

Some of the hindering factors identified in the current study have not been present in the literature specifically related to survivors, but have been identified in research involving hindering experiences for clients with a variety of presenting issues. For example, the hindrance of therapy sessions being too short (Bowman & Fine, 2000; Paulson et al., 2001) and not seeking counselling soon enough (Lambert & Cattani-Thomson, 1996; Paulson et al., 2001) were previously identified in the literature regarding hindering events in therapy with clients in general and the current study suggests that these findings also apply to survivors of childhood sexual abuse.

While studies involving clients with a variety of presenting issues offer valuable insight into hindering aspects of therapy in general, relying on them for information regarding what hinders healing for survivors of childhood sexual abuse could result in important information being overlooked. For example, hindering influences such as not being believed and having a therapist display shock may be more likely to occur and to interfere with healing when the presenting issues involve overcoming childhood sexual abuse since it usually involves more shame and secrecy than with issues such as job dissatisfaction, parenting or self-esteem concerns. Many of the hindering influences that emerged in the current investigation—the role of unsupportive people following disclosure, lack of hope, not having specific memories, and having difficulty forgiving the offender—have not been identified in studies that involved clients with less traumatic presenting issues. This suggests that some of the factors that interfere with healing may be specific to survivors of childhood sexual abuse.

External Factors

External hindrances include a diverse collection of interfering factors related to difficulties with the mechanics of therapy such as misdiagnosis, lack of resources and limited money and associated with individual or situational variables such as moving frequently, lacking an education, and having ongoing contact with one's offender. It seems that the current literature on healing from childhood sexual abuse has not adequately recognized these factors as negatively impacting healing for survivors of childhood sexual abuse. Their emergence as hindering impacts indicates the need for a greater awareness of hindering influences that occur outside of the therapy session.

Interestingly, many of the hindering aspects of healing for survivors of childhood sexual abuse are in direct opposition to impacts that were described as facilitating healing in the first concept map. For example, where hindrances speak of insufficient insight and action, helpful factors include developing self-acceptance and new skills. Similarly, feeling isolated is in contrast to connecting with others and sharing of self. Likewise, unsupportive people are in opposition to having a strong support system.

It is important to note that for this study a single concept map focused on all hindering experiences—those within therapy and those outside of therapy. The resulting map included numerous themes of hindering factors with one cluster being exclusively related to negative experiences in therapy. On the other hand, when investigating factors that facilitated healing, two questions were asked and two maps were generated—the first focused on helpful aspects in general and the second focused on helpful aspects within therapy. It is likely that a more complete understanding of the negative experiences in therapy could be gained by separating out hindering aspects of therapy from factors that interfered with healing in general.

Helpful Therapy Impacts

The concept map regarding helpful impacts of therapy described client-focused factors and therapy-focused factors. Each of these areas will be briefly addressed before being examined in further detail.

Client-focused factors included the emergence of new findings that involved illuminating the process of redefining self. Aspects of redefining self that had been acknowledged in previous studies included learning to cope and express feelings and learning not to blame themselves (Godbey & Hutchinson, 1996; Malmo & Laidlaw, 1995; Palmer et al., 2004). However, issues of self-worth, re-examining childhood experiences, learning to ask for what is needed and learning to trust emerged as new components of redefining self for survivors. Support for previous findings regarding the importance of client-focused issues such as developing new perspectives and skills (Elliott & James, 1989; Lietaer, 1992; Llweelyn et al., 1988; Paulson et al., 1999) and telling one's story (Elliott & James, 1989; Paulson et al., 1999) was also evident.

Therapy-focused factors that emerged are consistent with previous findings related to the helpfulness of having a positive therapeutic relationship (Asay & Lambert, 1999; Bachelor & Horvath, 1999; Beutler et al., 2004; Elliott & James, 1989; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Lietaer, 1992; Orlinsky et al., 2004; Wampold, 2001) and a supportive therapist (Elliott & James, 1989; Hill et al., 1988; Lietaer, 1992; Orlinsky et al, 2004; Paulson et al., 1999; Wampold, 2001). Support is also offered for previous findings regarding the helpfulness of having a therapist who was available (Draucker & Petrovic, 1997 & Paulson et al., 1999), who used self-disclosure (Beutler et al., 2004; Hill et al., 1988; Lietaer, 1992), who set goals (Draucker & Petrovic, 1997; Palmer et al., 2004) and who encouraged the use of additional resources outside of the therapy sessions (Beutler et al., 2004; Elliott & James, 1989; Malmo & Laidlaw, 1995; Paulson et al., 1999). In addition, the current findings were consistent with an earlier study that noted the importance of having access to affordable therapy (Paulson et al., 1999).

Client-Focused

A new finding regarding helpful impacts in therapy is the emergence of the importance placed on the redefining of one's self by participants. Some of the issues related to this theme of redefining self have been identified in existing literature regarding healing such as learning to cope with the effects of the sexual abuse (Malmo & Laidlaw, 1995), learning not to blame themselves (Godbey & Hutchinson, 1996) and learning to express feelings (Godbey & Hutchinson, 1996; Palmer et al., 2004). However, other aspects of redefining self have not been clearly articulated as helpful impacts in therapy when healing from childhood sexual abuse. For example, tasks such as recognizing self-worth, re-examining childhood experiences, learning to ask for what is needed, and learning to trust all emerged as contributing to the process of redefining of self.

This new finding with a focus on redefining self may have emerged because of the nature of the issues being addressed in therapy—healing from childhood sexual abuse. In a study involving a similar concept mapping approach aimed at understanding client perceptions of helpful experiences in counselling (Paulson et al., 1999), participants were drawn from a clinical setting and presented in therapy for issues such as depression, childhood issues, relationship issues, emotions, career, and personal validation. Even with the inclusion of a diversity of clinical issues, the study by Paulson et al. did not identify changes that involved a "redefining of self". Rather, changes included more behavioural and content-level changes such as learning skills, gaining new perspectives and increasing knowledge (Paulson et al., 1999). Similarly, other studies that primarily involved clients with presenting issues that did not impact the core of self to the same degree as clients who have experienced childhood sexual abuse have not identified the helpfulness of redefining self through therapy (Elliott, 1985; Hill et al., 1988; Lietaer, 1992; Martin & Stelmaczonek, 1988).

Additional support for the emergence of redefining self as relevant when healing from childhood sexual abuse is found by considering research regarding the consequences of childhood sexual abuse. It has been said that the long-term effects of childhood sexual abuse include impairments in *self* and social-functioning (Cole & Putnam, 1992) and attachment literature contends that childhood sexual abuse is associated with insecure attachment styles that result in internalized working models of self that are distorted or unhealthy (Alexander, 1992; Levy & Orlans, 1998; Peluso et al., 2004; Swanson & Mallinckrodt, 2001). Given these identified impacts on *self*, it makes intuitive sense that therapy would involve a redefining of self. Healing from childhood sexual abuse involves using the therapeutic relationship as a secure base in order to assign new meaning to a person's internalized sense of self (Slade, 1999).

One final piece of support for redefining of self as a new part of therapy with survivors of childhood sexual abuse can be found by examining results of a study by Valentine and Feinauer (1993) that investigated resiliency factors of individuals who had been sexually abuse in childhood but who were functioning well. The qualities possessed by the women in this study were strikingly similar to the helpful impacts involved in "Redefining of Self" through therapy. For example, the high-functioning survivors in the study by Valentine and Feinauer made external attributions about the abuse, recognizing it was not their fault and putting it into perspective whereas in the current study, part of redefining self included re-examining childhood experiences and learning not to blame themselves for the abuse. The women in the previous study had a sense of belief in themselves or "self-regard" (Valentine & Feinauer, 1993) whereas redefining of self involved recognizing one's self-worth. Similarly, the resilient women in the study by Valentine and Feinauer had a sense of personal power whereas for the survivors in the current study, this sense of power was gained through redefining of self that included learning to ask for what is needed, learning to trust people, learning to cope with the effects, and learning to express feelings. Thus, the cluster "Redefining of Self" as an important and helpful aspect of therapy may be unique to survivors of childhood sexual abuse or to others with experiences that have similar negative impacts on self.

In addition to the new finding of redefining self, support for the importance of developing new perspectives and skills was also evident. Where the current study highlights the importance of "Developing New Perspectives and Skills" in therapy, activities similar to these have been described in previous literature in a variety of ways including "New Perspectives" and "Gaining Knowledge" (Paulson et al., 1999), "Self-Understanding and Insight" (Elliott & James, 1989), "Problem solution" and "Awareness" (Llewelyn et al., 1988), and "Self-exploration" and "Experiential Insight" (Lietaer, 1992). As well, survivors in the present investigation support previous findings that describe activities such telling one's story or client self-disclosure as helpful to healing (Elliott & James, 1989; Paulson et al., 1999).

Therapy-Focused

Participants in this study provide support for the importance of the therapeutic relationship and identify aspects of the therapeutic alliance that survivors experienced as helpful as including three sub-themes—*positive therapist attitude, therapist interventions and actions, and mutuality in the* relationship. These findings about the importance of the therapeutic alliance are consistent with what many researchers have previously concluded regarding the therapeutic alliance being a common or general factor that produces change in therapy (Asay & Lambert, 1999; Bachelor & Horvath, 1999; Beutler et al., 2004; Elliott & James, 1989; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Lietaer, 1992; Orlinsky et al., 2004; Wampold, 2001). The therapeutic alliance is a key component of psychotherapy and the quality of the therapeutic alliance early in therapy can successfully predict long-term treatment benefits (Beutler et al., 2004). Furthermore, the importance of the therapeutic relationship is especially true when considered from the perspective of the client (Orlinsky et al., 2004).

On the concept map related to helpful impacts in therapy, the cluster focused on the therapist being supportive overlaps with the cluster that highlights the importance of having a positive therapeutic relationship. This overlap makes intuitive sense since it is difficult to separate the therapist as a person from the process of therapy. Many researchers have recognized the importance of therapist behaviours and/or characteristics in therapy (Elliott & James, 1989; Hill et al., 1988; Lietaer, 1992; Orlinsky et al, 2004; Paulson et al., 1999; Wampold, 2001). As Wampold (2001) describes, "The essence of therapy is embodied in the therapist…and the person of the therapist is a critical factor in the success of therapy" (p. 202). Research examining the therapeutic relationship recognizes the role of therapists' contributions in influencing its qualities, thereby offering further support to the connection of the therapist and the therapeutic relationship (Beutler et al., 2004; Orlinsky et al., 2004; Paulson et al., 1999; Roth & Fonagy, 1996).

The current study offers further support for the importance of a positive therapeutic relationship with a supportive therapist. Specifically related to survivors of childhood sexual abuse, numerous previous studies identify the impact that positive, supportive relationships have on healing (Armsworth, 1989; Draucker & Petrovic, 1997; Edmond et al., 2004; Feinauer, 1989; Glaister & Abel, 2001; Godbey & Hutchinson, 1996). When considering literature on group therapy, group cohesion is considered comparable to the therapeutic alliance (Orlinsky et al., 2004). Studies involving survivors in group therapy consistently suggest that group cohesion (or qualities associated with it) is helpful and important to healing (Bonney et al., 1986; Hall & King, 1997; Palmer et al., 2004; Wheeler et al., 1986).

Issues pertaining to therapist availability have been previously identified as important (Draucker & Petrovic, 1997; Paulson et al., 1999) and were supported by the current study which identified helpful factors such as having regular appointments, being accessible by phone, and arranging coverage when absent as facilitating healing. In addition, the helpfulness of setting goals with the therapist was also reinforced (Draucker & Petrovic, 1997; Palmer et al., 2004).

Participants indicated that therapist self-disclosure had a helpful influence on their healing. Although therapist disclosure or sharing of personal information has received some attention in existing research, it is considered an emerging and potentially important area of research (Beutler et al., 2004). Previous research has suggested that appropriate self-disclosure on the part of the therapist can be helpful in therapy (Hill et al., 1988; Lietaer, 1992) although additional research is needed (Beutler et al., 2004). According to Beutler et al., therapist self-disclosure indicates a statistically significant but clinically weak relationship to outcome and additional research is needed to draw conclusions about its impact and relationship to outcome.

Participants described accessing resources beyond the session as having important implications for healing. This involved focussing on activities suggested by the therapist although the events usually occurred outside of the therapy session such as doing homework, reading, accessing other professionals and using artistic means to explore feelings. These findings regarding accessing external resources are consistent with previous results which suggest that accessing resources outside of therapy is an important aspect of healing (Beutler et al., 2004; Elliott & James, 1989; Malmo & Laidlaw, 1995; Palmer et al., 2004; Paulson et al., 1999). The affordability of counselling services was seen as a pertinent factor, supporting previous findings by Paulson et al. who suggested that financial considerations might be more noteworthy than formerly recognized.

Before concluding this discussion regarding what aspects of therapy were helpful in overcoming childhood sexual abuse, it is interesting to note the striking similarity to the research conducted by Paulson et al. (1999). It would seem that regardless of the issues being addressed, clients perceive many of the same aspects as helpful. Nevertheless, some important differences between the two studies do emerge that may suggest some helpful therapy impacts are unique to survivors such as the importance of redefining self.

Limitations of this Study

The purpose of this study was exploratory in nature and therefore, the findings are preliminary and interpretations must occur with several limiting factors in mind. More specifically, the findings of this study must be viewed in light of limitations related to its sample characteristics, retrospective nature, limited questions to gather information, and lack of frequency data.

This study used a purposive sample composed entirely of volunteers who may differ from the general population of survivors healing in ways such as motivation, level of functioning or experiences regarding healing. Despite efforts to include a culturally diverse population, most of the participants were Caucasian. Although some participants had never attended therapy focused on the abuse they experienced, including more survivors who have never attended therapy may offer additional insight as to the non-therapy related influences on healing.

Another concern regarding this study is its retrospective nature that relies on self-reporting by participants. As such, responses are based on individuals recalling their experience and these descriptions are subject to distortions such as forgetting information and interpreting or describing the experience based on one's current understanding rather than on one's understanding at the time the event occurred. Also, the participants may have edited or altered their descriptions in order to present favourably to the researcher. In order to minimize the desire to alter responses due to the presence of the researcher, participants were encouraged to return their questionnaires anonymously.

It is important to note that although efforts were made to ensure that the entire domain of the experience of healing from childhood sexual abuse was described (i.e., seeking participants until no new ideas were being generated), it is entirely possible that a larger or different sample would generate additional items describing helpful and hindering influences on healing. Thus, the list of statements represented by the concept maps may not necessarily cover the entire domain of what helps and hinders healing from childhood sexual abuse.

The current study directly asked about helpful events in healing in general and, more specifically, about helpful events in counselling in an attempt to ensure the strategies identified highlighted influences to healing that occurred both within and outside of therapy. Due to time and data management constraints, however, hindering events were addressed as an entire domain regardless of whether the influences occurred within therapy or outside of therapy. When exploring hindering experiences, one cluster did emerge that clearly delineated negative experiences in therapy. Comparisons between the number of helpful versus hindering events in therapy cannot be made based on the findings from this study since participants were provided with a greater opportunity to report their helpful experiences (two questions) than their hindering experiences (one question). Had there been a separate question regarding interfering or hindering events in therapy, it is likely that additional issues would have emerged.

Although this study identified themes regarding helpful and hindering influences on healing from childhood sexual abuse, the frequency with which these statements are endorsed has not been assessed. Thus, the themes that emerged should not be viewed as having a high frequency of occurrence. Additional data is required to make such an assumption. Furthermore, it is recommended that future rating scales differentiate more clearly between "not applicable" because it was never experienced and "not helpful or hindering" because it was experienced but was not perceived to have an impact. Making this distinction would allow for a more complete understanding of some of the results such as the low rating for the item "Having my offender admit to having sexually abused me". Since concept mapping generates preliminary data about a particular issue, additional research is needed to establish the bigger picture about what factors help and hinder healing from childhood sexual abuse.

Implications for Counselling and Healing

The perspective of survivors has much to offer regarding helpful and hindering impacts when healing from childhood sexual abuse. The implications of the current study for counselling and healing can best be understood by considering factors associated to relationship with self and relationships with others.

The need for survivors of childhood sexual abuse to develop a healthy sense of self emerged clearly in this study. Whether in therapy or in life outside of therapy, survivors need to be encouraged to maintain an accepting, patient, and nurturing view of themselves. This may involve a redefining of self that includes resolving issues of self-worth, identifying and meeting needs, learning to trust, and redefining of childhood experiences. In addition, addressing ways in which survivors may be interfering with their own healing is important in order to facilitate healing. For example, survivors may be engaging in self-destructive behaviours, making poor choices in relationships, struggling with feelings of hopelessness or isolation, and blaming themselves for the abuse. Furthermore, it might be helpful to allow survivors the opportunity to tell their story and to encourage them to make a conscious decision to not be a victim any longer.

Current findings offer support to previous research that has already emphasized the importance of being involved in supportive relationships when healing from childhood sexual abuse. It is imperative that therapists attend not only to the quality of the therapeutic relationship, but also to relationships that survivors are involved with outside of the therapy session. Relationships that are supportive, validating and affirming allow the survivor a context in which to learn about themselves, others and relationships in a positive way. The hindering or interfering impacts of therapy described by participants are alarming--denial of survivors' experiences, disbelief regarding the abuse, exploitation or victimization of clients, and a lack of understanding abuse issues—and suggest the need for improved training and greater therapist accountability.

Through the current study, our understanding of the role of others in healing has been expanded by a greater understanding of the potentially hindering impact that others can have on healing, particularly after disclosure of the abuse. Reactions to disclosures need to be reviewed in order to identify potentially hindering experiences such as survivors being blamed for the abuse, losing relationships because of the disclosure and not being supported or believed by others. In addition, when examining other relationships, this study suggests that addressing issues related to the offender is important: Was the survivor protected from the offender? Does the survivor still have contact with the offender? Did the offender admit to the abuse? Did the survivor confront or take any action against the offender? Has the survivor forgiven the offender? By exploring these offender-related issues, the survivor can work through issues that may be interfering with healing.

Given that healing from childhood sexual abuse potentially involves issues such as redefining self and needing to experience supportive relationships, it is unlikely that treatment with survivors will fit into short-term models of therapy that are favoured by insurance companies and employee assistance programs. Treatment approaches that emphasize symptom resolution and behaviour change will do little to facilitate the "redefining of self" or to address relationship issues that are often necessary for survivors. For example, according to attachment theory, a survivor would enter therapy and form a secure attachment with the therapist, subsequently enabling the client to use the therapeutic relationship as a base from which to venture in order to assign new meaning to his/her internalized sense of self, of others and of relationships (Slade, 1999). Forming such a relationship and undertaking such tasks highlight the importance of long-term therapy being available to survivors of childhood sexual abuse. The survivors in this study have highlighted the need for such therapy to be affordable and accessible.

On a final note, the current study serves as a reminder that attending therapy reflects only one piece of the healing that occurs for survivors who deal with a variety of hindering and helpful impacts in their lives. Therapists should encourage healing activities outside of therapy session and resources about healing should be made available to those survivors who never attend therapy. Maintaining a perspective that addresses healing and hindering factors both within and outside of therapy may be the best way to facilitate healing for survivors of childhood sexual abuse.

Recommendations for Future Research

Future research could seek to provide validation for the conceptual understanding that emerged from the survivors' descriptions by replicating this study with a different population, perhaps a larger and more culturally diverse sample. In addition, including a population involving more people who have never attended therapy may help to identify additional healing strategies that exist outside of therapy. Having larger and different samples generate statements about their experiences of healing would help increase confidence that the concept maps represent the complete domain of helpful and hindering influences. Also, questionnaires based on the concept maps could be designed to investigate the frequency of occurrence of the themes that emerged, thereby expanding our understanding of helpful and interfering influences.

By more specifically exploring some of the themes identified by participants, future research endeavours could further refine and develop the concept maps that resulted from this study. For example, the cluster related to "Redefining of Self" as a helpful aspect of therapy seems particularly worthy of additional research. Does this finding continue to occur with survivors of childhood sexual abuse? If so, does it occur for other populations as well? How do survivors characterize the process of "redefining of self"? Some of the other themes highlighted by this exploratory study that could be pursued in future research to further our understanding of healing from childhood sexual abuse include the impact of offender-related issues, external hindrances and post-disclosure responses.

In this study, spirituality is identified as influencing healing in all three concepts maps with references to impacts such as experiencing the supernatural healing power of God, participating in spiritual practices or rituals, growing up with a negative view of spirituality, and having spirituality included in therapy. Although these ideas related to spirituality did not emerge as a coherent theme or cluster, their identification by survivors as impacting healing is noteworthy as a potentially important influence that requires further exploration. Research focused primarily on the role of spirituality in healing from childhood sexual abuse is minimal (Feinauer et al., 2003; Turell & Thomas, 2001) although the role of spirituality is mentioned in several studies involving survivors (Glaister & Abel, 2001; Malmo & Laidlaw, 1995; Valentine & Feinauer, 1993) thereby suggesting that it may play a more central role in healing than currently recognized. Although the relationship between spirituality and physical and mental health has been well-documented, spirituality is rarely mentioned as a possible helpful impact or cause of therapeutic effects (Lambert et al., 2004). The role of spirituality in therapy has been neglected in recent literature and the findings that do exist are inconclusive (Beutler et al., 2004). Within a therapy setting, spiritual concerns of clients are often ignored (Turell & Thomas, 2001). The inclusion of spirituality in therapy as helpful to survivors of childhood sexual abuse requires additional investigation.

Other avenues worthy of future research include further examination of influences on healing during therapy. For example, research focused on the therapeutic relationship could focus on the sub-themes of "Experiencing a Positive Therapeutic Relationship" identified by participants which included—*positive therapist attitude, therapist interventions and actions, and mutuality in the relationship.* Do these themes consistently emerge as important aspects of the therapeutic relationship from the perspective of the survivor or client? Regarding the map on hindering influences, the cluster "Negative Experiences in Therapy" could become the focus of an entire research question. Client perceptions of hindering events in counselling, particularly for survivors of childhood sexual abuse, are under-represented in the research. The concepts that emerge regarding helpful and hindering aspects of therapy could be used to develop feedback questionnaires for the training and assessment of therapists.

Future research could use the findings of this research to develop a survey to be used as a screening instrument for assessing what healing and hindering influences most impact a person's life. Such a screening tool could draw attention to the survivor's strengths as well as to areas that could be addressed in order to facilitate a more holistic approach to healing. Survivors could use such an instrument to take inventory of their own healing strategies and to highlight other ideas that might facilitate their healing. Counsellors could use it as a guide to identify areas to target through treatment. For example, survivors who endorse very few items related to "Connecting with Others" could be encouraged to access other healthcare professionals or learn about other survivors through reading or attending groups.

In terms of the concept mapping approach, future research could have different samples of participants sort the items related to each question in order to examine any variations in concept maps based on what group completes the sorting tasks. Do the results change if only therapists do the sorting tasks? Do the concept maps based on the sorts of therapists differ from the maps based on the sorts of survivors? What if non-survivors do the sorts? What if the new group doing the sorting tasks is similar to the original sorters? How consistent are the subsequent themes that emerge? Similar results based on different samples of sorters would increase our confidence in both the results of this study specifically and in the concept mapping process more generally.

Concept mapping is exploratory in nature and additional research regarding helpful and hindering experiences in healing from childhood sexual abuse is needed. Through this study a glimpse into the healing experiences of survivors is offered. Through ongoing research in this area, a deeper understanding can be gained. The men and women who have endured childhood sexual abuse and who are subsequently able to lead stable and productive lives have much to teach us about healing, growing, and moving on.

Summary

The goals of this study were to explore the experience of healing from childhood sexual abuse to gain a conceptual understanding of what survivors believe facilitate and hinder their healing. More specifically, the focus was to understand what factors help healing, what hinders or interferes with healing, and what aspects of therapy facilitate healing. Using a concept mapping approach, descriptions of survivors' experiences were gathered and analyzed. In this way, the constructs were identified by the participants rather than predefined by the researcher. The results of this study include three pictorial maps related to what helped healing, what interfered with healing, and what in therapy helped healing.

The concept map related to what helped survivors heal from childhood sexual abuse is consistent with much of what is already known about healing—healthy, supportive relationships play a key role in facilitating healing. Internet support was noted as a new way in which these relationships sometimes occurred. New findings suggest that the importance of developing self-acceptance is more critical than previous research on healing from childhood abuse has indicated. In addition, resolving offender related issues emerged as playing a more important role in healing than previously suggested.

Literature regarding survivors' perceptions of factors that hinder overcoming childhood sexual abuse is scarce and therefore the concept map regarding hindering events in healing makes a contribution to existing research by exploring factors that interfere with healing that occur both within and outside of a therapeutic context. The current study is consistent with research suggesting that survivors' perceptions, feelings and behaviours interfere with their own healing. New findings indicate that having little hope of healing, lacking specific memories about the abuse, and being unable to forgive the offender may interfere with healing. In addition, the current study highlights additional ways in which external factors interfere with healing (e.g., being misdiagnosed, lacking of resources, moving frequently, lacking an education and maintaining contact with one's offender).

The concept map regarding helpful aspects of therapy with survivors of childhood sexual abuse supported existing research based on helpful aspects of therapy with clients who present with a variety of issues. In therapy, regardless of the presenting issues, the importance of having a supportive therapist and positive therapeutic relationship is clear. By focusing specifically on survivors of childhood sexual abuse, our understanding of helpful impacts was enhanced by the emergence of the emphasis on redefining one's self. Additional research is needed to confirm and expand upon these findings.

A brief comparison of the three concept maps reveals some interesting patterns regarding the main themes that emerged through this research—relationship with self and relationships with others. The prominence of the theme of "self" is evident in all three maps. For example, helpful impacts involve developing self-acceptance; hindering impacts include having negative thoughts about self and needing to function normally while feeling broken; and, a major theme regarding helpful events in therapy included the redefining of self. Similarly, the importance of the role of relationships with others to healing is evident on all three maps: helpful impacts focus on connecting with others, having a strong support system, and being validated; hindering impacts include unsupportive people and negative therapy experiences; and, helpful factors in therapy emphasize having a supportive therapist and a positive therapeutic relationship. These themes emphasize the importance of relationships when healing from childhood sexual abuse--relationship with self and relationships with others.

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Appendix A: Study Description

Title: **Healing from Childhood Sexual Abuse**

Principle Researcher: Mary Pudmoreff, M.Ed.
c/o Dr. Barbara Paulson
6-102 Education North Department of Educational Psychology
University of Alberta, Edmonton T6G 2G5
Or phone 780-416-0224 or e-mail at mystudy@telusplanet.net
Academic Advisor: Dr. Barbara Paulson, Department of Educational Psychology
University of Alberta Phone: 780-492-5298

Hello! My name is Mary Pudmoreff and I am a PhD student in the Counselling Psychology program at the University of Alberta. For my dissertation, I am doing research aimed at gaining a better understanding of **what is helpful and unhelpful when overcoming or healing childhood sexual abuse**. It is hoped that this information will highlight strategies for healing that will be useful for adult survivors of childhood sexual abuse as well as for therapists and other individuals who support survivors.
I am seeking participants who:

- are at least **21 years old**
- **experienced sexual abuse in childhood**
- feel that they **have achieved at least a fair or moderate "degree of healing or recovery"** (In your daily life, are the negative effects of childhood sexual abuse relatively few? Would you say that you have worked through "most" or "a good portion" of the issues that surface for many survivors of abuse? Would you consider yourself to be "mostly healed"?)

If these characteristics describe you, I would love to hear about what helped you overcome the childhood abuse you experienced. This research will involve three phases and you can participate in one, two or all three of the phases.

Currently, for the first phase of my study, I am seeking individuals who meet the above description and **who would be willing to provide some demographic information and answer a few open-ended questions** about what helped them to heal or overcome the abuse. This task would take you approximately 30 to 45 minutes and could be completed anonymously with your responses being returned by mail.

If you are able to participate in this research, please contact me by phone at 780-416-0224 or by e-mail at mystudy@telusplanet.net to arrange for a copy of the demographics form and questionnaire. Also, if you would like more information or have any questions, please feel free to contact me.
I would like to thank-you for your time and interest.

Sincerely,

Mary Pudmoreff, M.Ed.

Please note the following:
-The results of this study will be used for my doctoral dissertation and may be used in subsequent professional publications and presentations.
-The intended purpose of this research is as described above. No deception will be used.
-The confidentiality and anonymity of all participants will be protected through the use of anonymous responses, the removal of identifying information, and implementation of a coding system when appropriate.
-Participants may accept or decline to participate and are free to withdraw from the project at any time, without penalty.
-It is recognized that the topic of sexual abuse may create discomfort for some participants. The researcher will be available to participants for support and confidential referral.

Appendix B: Demographic and Information Sheet

You should have already received a copy of the Study Description that outlines your rights as a participant in this research. If you have not seen this form, please ask me for a copy. Your completion of this form acts as you providing your informed consent. If you have any questions, please do not hesitate to contact me.

In order to know a little bit of information about the participants in this study, I ask that you please complete ALL of the following questions. Do NOT include your name. All responses will be treated as confidential and will only be reported in terms to describe the group of participants.

1. Gender: _____female _______ male
2. Age: ______
3. Ethnicity/Cultural background: _____ Caucasian-Canadian (White)
   _____ First-Nations-Canadian (Aboriginal)
   _____ Indo-Canadian (India)
   _____ Asian-Canadian
   _____ African-Canadian
   _____ Other—please specify: ______________________________
4. Marital Status:
   _____ Never married
   ____ Common-Law
   _____ Married
   _____ Separated
   _____ Divorced
   _____ Remarried
   _____ Widowed
   _____ Other, please specify: _________
5. Do you have children? _____ no ______ yes; if yes, how many? ______
6. How many different people sexually abused you when you were a child? ______
7. How old were you when you were sexually abused? ___________________
8. How many of your offenders were female? _____ How many offenders were male? ______
9. In total, on how many different occasions were you sexually abused?
   _____ once
   _____ 2 – 10 times
   _____ 11 – 20 times
   _____ over 20 times
10. Did you know the person/people who sexually abused you? _____ no (stranger) _____ yes
11. Was/were the offender(s) related to you? _____ no _____ yes; if yes, what was the relationship(s):
12. Have you ever attended therapy or counselling? _____ No _____ Yes

➢ If yes, please answer the following questions:

Was the therapy/counselling focused on the effects of the sexual abuse? _____ No _____ Yes

Approximately how many sessions did you attend?
_____ Less than 6 sessions
_____ 6 - 10 sessions
_____ 10 - 20 sessions
_____ over 20 sessions

Please return this **demographic form with any other forms** you were asked to complete to **Mary Pudmoreff** in whichever way is most convenient for you:

- **In person**, by prior arrangement or to arrange call me at **416-0224**
- By **e-mail to mystudy@telusplanet.net** or
- By traditional **mail to: Mary Pudmoreff**

c/o Dr. Barbara Paulson
6-102 Education North
Department of Educational Psychology
University of Alberta, Edmonton T6G 2G5

If you would like a summary of the final results of this study, please provide the researcher with a written request that includes your name and mailing address or e-mail address

Appendix C: Questionnaire

Questionnaire: Healing from Childhood Sexual Abuse

You should have already received a copy of the Study Description that outlines your rights as a participant in this research. If you have not seen this form, please ask me for a copy. Your completion of the demographic form and this questionnaire acts as you providing your informed consent. If you have any questions, please do not hesitate to contact me.

Which ONE statement most closely reflects how much you feel you have healed or overcome the abuse:

_____ It never effected me in the first place so there was nothing to heal.
_____ I haven't really healed much at all. I've only just begun my journey.
_____ I've definitely started healing, but I'm only in the early stages.
_____ I'd say I'm about half-way through my healing. I've dealt with a lot, but I think there is still quite a bit more to do.
_____ I've dealt with lots and I'd say I've overcome almost all of the negative effects of the abuse. I think I'm almost done.
_____ I think that I have overcome the negative effects and that I'm completely healed.

Please answer the following 4 questions as completely as possible. Attach additional paper as required.

1) What has contributed to your overcoming the childhood sexual abuse you experienced? What has helped you heal from the childhood sexual abuse you experienced?

2) If you received counselling/therapy, please describe the aspects of it that were helpful in your healing or recovery.

3) What interfered with your healing from the childhood sexual abuse you experienced? What was unhelpful or got in the way of your recovery?

4) Is there anything else you would like to describe about what has helped or not helped your healing/recovery from childhood sexual abuse?

Please ensure that this 2 page questionnaire is returned with the demographics form

(3 pages to return in all)

If you would be willing to participate in the sorting task (Edmonton area participants only) **or the subsequent survey** (participants from everywhere), **please fill in the following information.** Detach and mail separately if desired.

Name: ______________________________ Phone Number: (__)______________
Mailing Address: ____
City/Town: __________________________ *Province/State:* ____________________
E-mail Address (if preferred): ____

Appendix D: Covering Letter for Phase II

(Sorting and Rating Tasks)

Dear Research Participant:

Hello! You are receiving this package because you indicated that you were interested in participating in this phase of my research regarding healing from childhood sexual abuse. As you are aware, this study is being carried out at the University of Alberta to develop a better understanding of what is helpful and unhelpful when overcoming childhood sexual abuse. It is hoped that this information will highlight strategies for healing that will be useful for adult survivors of childhood sexual abuse as well as for therapists and other individuals who support survivors.

During Phase One of this study, information was collected from survivors about their experience of healing. The information was then pooled together and lists of statements representing their responses to each question were generated. I am now entering Phase Two of the study, which involves having survivors rate and sort the statements collected in order to develop themes about the experience of healing from childhood sexual abuse.

Please complete the tasks described on the attached page entitled "What Do I Do?" (blue page). Your decision to become involved in this research is completely voluntary and anonymous. Please do not put your name on any of the forms. Your answers will be completely confidential and only group results will be reported. Returning the completed tasks will be viewed as you giving your consent to participate in the project and you are free to withdraw your participation at any time.

If you have any questions, please contact **Mary Pudmoreff** at **mystudy@telusplanet.net** or phone **(780) 416-0224** or you can reach me by mail at:

Mary Pudmoreff, Ph.D. (Candidate)
c/o Dr. Barbara Paulson
6-102 Education North
Department of Educational Psychology
University of Alberta, Edmonton, AB
T6G 2G5

Thank you for agreeing to take part in this study and for giving so generously of your time.
Gratefully,

Mary Pudmoreff, Ph.D. (Candidate)
Department of Educational Psychology
University of Alberta
Thesis Supervisor: Barbara Paulson, Ph.D.
Department of Educational Psychology
University of Alberta Phone: (780) 492-5298

Appendix E: What Do I Do?

1) Check to ensure you have all of the following information in your package:

- ✓ Letter to Research Participant (describes study, explains your rights, and provides contact information)
- ✓ "Demographics & Information Sheet" (must be completed and returned with package)
- ✓ One medium sized envelope for each question that you agreed to rate and sort; and in each medium sized envelope there should be:
  - ➢ Instructions for rating task and statements to rate (stapled together)
  - ➢ Instructions for sorting task
  - ➢ White envelope containing statements written on a slips of paper (to sort)
- ✓ Large Self-Addressed Envelope for returning information (postage pre-paid within Canada)
- ✓ "Postage Reimbursement Form" (if outside of Canada)
- ✓ "Checklist of Completed Tasks" (red paper)

2) Complete Demographics & Information Sheet and put it in Return Envelope

3) Open the medium sized envelopes labelled Question #1, #2 or #3

(If rating and sorting for more than one question, just open one of the envelopes at a time)

- ➢ Read and follow the directions for the Rating Task
- ➢ Read and follow the directions for the Sorting Task
- ➢ When done the rating and sorting, return all of the information to the medium sized envelope you took it out of (there should be rating statements and a white envelope containing sorting slips stapled together according to how you sorted them);
- ➢ Place this medium sized envelope in the addressed return envelope provided.
- ➢ Note: I must have answers to ALL of the rating statements and ALL of the slips must be included in the sort for me to be able to use your responses.

4) If you are rating/sorting more than one question, follow step#3 for each one

- ➢ If you are sorting more than one question, please do each question separately. The statements for each question are printed on its own color of paper, please do not mix the information (for example, do not sort statements from question #1 with statements from question #2).

5) If desired, complete the Postage Reimbursement Form

- ➢ For those participants responding from outside of Canada, I am unable to provide a pre-stamped package for returning your information. However, I would be pleased to reimburse you for your out-of-pocket postage expenses. If you would like to be reimbursed, simply complete the Postage Reimbursement Form.
- ➢ In order to remain anonymous, please return the postage form to me separately with the amount owing indicated on it.

6) Complete the Checklist of Completed Tasks (on red paper)

7) Mail the package back to me at your earliest convenience

If you have any questions or concerns, please contact Mary Pudmoreff at mystudy@telusplanet.net or by phone at 780-416-0224.

Thank you so much for your assistance!

Appendix F: Demographic & Information Sheet

In order to know a little bit of information about the participants in this study, I ask that you please complete ALL of the following questions. Do NOT include your name. All responses will be treated as confidential and will only be reported in terms to describe the group of participants.

1. Gender: _____female _______ male
2. Age: ______
3. Ethnicity/Cultural background:
   - _____ Caucasian-Canadian (White)
   - _____ First-Nations-Canadian (Aboriginal)
   - _____ Indo-Canadian (India)
   - _____ Asian-Canadian
   - _____ African-Canadian
   - _____ Other—please specify: ______________
4. Marital Status:
   - _____ Never married
   - _____ Common-Law
   - _____ Married
   - _____ Remarried
   - _____ Divorced
   - _____ Other, please specify: ______________
   - ____ Separated
   - _____ Widowed
5. Do you have children? _____ No ______ Yes If yes, how many? ______
6. How many different people sexually abused you when you were a child? ______
7. How old were you when you were sexually abused? ____________________
8. How many of your offenders were female? _____ How many offenders were male? ______
9. In total, on how many different occasions were you sexually abused?
   - _____ once
   - _____ 2 – 10 times
   - _____ 11 – 20 times
   - _____ over 20 times
10. Did you know the person/people who sexually abused you? _____ no (stranger) _____ yes
11. Was/were the offender(s) related to you? _____ No _____ Yes
    - ➢ If Yes, what was the relationship(s): ____
12. Have you ever attended therapy or counselling? _____ No _____ Yes
    - ➢ If yes, please answer the following questions:

    Was the therapy/counselling focused on the effects of the sexual abuse? ___ No ___ Yes

    Approximately how many sessions did you attend?
    - _____ Less than 6 sessions
    - _____ 6 - 10 sessions
    - _____ 11 - 20 sessions
    - _____ over 20 sessions
13. Which ONE statement most closely reflects how much you feel you have overcome the abuse:
    - __ It never effected me in the first place so there was nothing to heal.
    - __ I haven't really healed much at all. I've only just begun my journey.
    - __ I've definitely started healing, but I'm only in the early stages.
    - __ I'd say I'm about half-way through my healing. I've dealt with a lot, but I think there is still quite a bit more to do.
    - __ I've dealt with lots and I'd say I've overcome almost all of the negative effects of the abuse. I think I'm almost done.
    - __ I think that I have overcome the negative effects and that I'm completely healed.
14. Did you participate in the first phase of this research (responding to open-ended questions about healing) ___ No ___ Yes

Please return this demographic form with the other tasks you are completing in the envelope provided

Appendix G: Checklist of Completed Tasks

(complete and return to researcher)

	Circle Answer
Have you completed the **Demographic & Information Sheet** and put it in the return envelope? (This must be returned for me to use your responses)	No Yes
Which question(s) did you do the Rating and Sorting Tasks for? (circle all that apply) note: both the rating and sorting tasks must be returned in full in order for your responses to be included in this study	Question #1 Question #2 Question #3
For **EACH question** that you did rating and sorting tasks for, are you returning a **medium-sized envelope** labelled with the question number and containing: The **Rating Scale** completed for every statement A **white envelope containing ALL the slips of papers** used for the sorting task, stapled together according to how you grouped them	No Yes
If you are returning this by mail, would you like to be reimbursed for your out-of-pocket postage expenses?	No Yes
If yes, have you completed the **Postage Reimbursement** form and mailed it separately.	No Yes

Now that you have completed this summary form, please include it in the package and return the package to me at your earliest convenience.

Thank-you so much for your time and assistance.

If you would like a summary of the results please provide me with a written request and your e-mail address (or, if e-mail is not available, then your regular mailing address).

Gratefully,

Mary Pudmoreff

Appendix H: Sorting Instructions for Question #1

In the attached white envelope you will find 69 slips of paper. Each slip of paper has a statement on it that was made by previous research participants in response to the question:

"What has contributed to your overcoming the childhood sexual abuse you experienced?"

Please read through these slips of paper and sort the slips into groups that you feel contain a common theme or idea. That is, sort these slips in a way that makes sense to you, according to how they seem to go together.
You may have as many groups as you like. Statements can be kept separate if they don't seem to belong to any group. However, please follow these rules:

- There has to be more than one pile
- There has to be less than 69 piles (i.e., each statement cannot be its own pile).
- Each statement can only be placed into one pile
- Only sort statements from Question #1 together (only green slips of paper with green slips of paper; relevant only if you are sorting more than one question).

Please note that throughout these statements,

- the term *therapist* refers to any person in a counselling role
(e.g., psychologist, psychiatrist, minister, pastor, counsellor etc)
- the term *offender* refers to the person or people who sexually abused you in childhood

Once you have finished sorting the statements into groups, please:

1) Staple each group together (hint: if a group is too large to be stapled, use an elastic band or a separate envelope to keep the pile of statements grouped together yet separate from the rest)

2) Place all stapled groups and any single-statement groups back into the white envelope that they came from and then put the white envelope (containing the stapled groups) back into the medium sized yellow envelope that is labelled "Question #1" (this envelope also contains the rating task for Question #1).

Thank-you for agreeing to take part in this study and for giving so generously of your time and effort. If you have any questions, please contact me by e-mail at mystudy@telusplanet.net or by telephone at (780) 416-0224.

Gratefully,
Mary Pudmoreff

Appendix I: Rating Instructions for Question #1

Previous research participants answered the question:

"What has contributed to your overcoming the childhood sexual abuse you experienced?".

From their answers a list of 69 statements was compiled to summarize how they described their experience of overcoming the childhood sexual abuse they experienced.
On the attached pages you will find the list of statements.

When you read each statement, focusing on your own experience, ask yourself:

How helpful was this in MY experience of overcoming childhood sexual abuse? Using the following scale, circle the number that best represents your response to each statement:

1	**2**	**3**	**4**	**5**
Not at all helpful (or not applicable)	**Slightly helpful**	**Somewhat helpful**	**Pretty helpful**	**Extremely helpful**

Please circle an answer for EVERY statement. Do not leave any blank.
If you have any questions, please contact me by e-mail at mystudy@telusplanet.net
or by telephone at (780) 416-0224.

Please note that throughout these statements,

- the term *therapist* refers to any person in a counselling role (e.g., psychologist, psychiatrist, minister, pastor, counsellor etc)
- the term *offender* refers to the person or people who sexually abused you in childhood

After rating ALL of the statements, please **place the list of rated statements back into the medium sized envelope marked Question #1** and, once the sorting task has been completed, place the medium sized envelope in the large self-addressed envelope provided.

Thank-you for taking part in this study and for giving so generously of your time.

Gratefully,

Mary Pudmoreff

Appendix J: Statements and Rating Scale for Question #1

Circle the number that best represents how well each statement describes your experience of what contributed to you overcoming childhood sexual abuse.

1	2	3	4	5
Not at all	**Slightly**	**Somewhat**	**Pretty much**	**Extremely well**

1.	Recognizing the ways the abuse connects to issues in my life.	1	2	3	4	5
2.	Confronting my fears.	1	2	3	4	5
3.	Receiving support from self-help programs I attended.	1	2	3	4	5
4.	Realizing that I can only change myself.	1	2	3	4	5
5.	Never having to see my offender again.	1	2	3	4	5
6.	Being validated.	1	2	3	4	5
7.	Being inspired by others who have healed from childhood sexual	1	2	3	4	5
8.	Being kept safe from self-destructive behaviours.	1	2	3	4	5
9.	Being patient with myself.	1	2	3	4	5
10.	My partner's strength.	1	2	3	4	5
11.	Having access to financial assistance.	1	2	3	4	5
12.	Maintaining a balanced life.	1	2	3	4	5
13.	Giving myself empowering messages.	1	2	3	4	5
14.	Having a pet.	1	2	3	4	5
15.	Being listened to.	1	2	3	4	5
16.	Accessing various healthcare professionals.	1	2	3	4	5
17.	Having someone confirm that the abuse occurred.	1	2	3	4	5
18.	Feeling safe.	1	2	3	4	5
19.	Having other people see my potential.	1	2	3	4	5
20.	Forgiving myself.	1	2	3	4	5
21.	Learning new ways to cope with the effects of the abuse.	1	2	3	4	5
22.	Deciding to stop being a victim.	1	2	3	4	5
23.	Taking medication.	1	2	3	4	5
24.	Other people being non-judgemental.	1	2	3	4	5
25.	Learning to be assertive.	1	2	3	4	5
26.	Having someone reach out to me.	1	2	3	4	5
27.	Re-examining beliefs I had formed in childhood.	1	2	3	4	5
28.	Drawing upon my personal strengths.	1	2	3	4	5
29.	Having supportive family members.	1	2	3	4	5
30.	Learning to be myself.	1	2	3	4	5
31.	Connecting with people who where supportive.	1	2	3	4	5
32.	Having time pass.	1	2	3	4	5
33.	Attending therapy.	1	2	3	4	5
34.	Learning how to protect myself.	1	2	3	4	5
35.	Helping other people.	1	2	3	4	5
36.	Being comfortable with all my feelings.	1	2	3	4	5
37.	Having my offender admit to having sexually abused me.	1	2	3	4	5
38.	Taking time to care for myself.	1	2	3	4	5

39. Experiencing the supernatural healing power of God. 1 2 3 4 5
40. People not giving up on me. 1 2 3 4 5
41. Being able to access support anonymously (e.g., crisis lines or 1 2 3 4 5
42. Learning self-acceptance. 1 2 3 4 5
43. Educating others about sexual abuse. 1 2 3 4 5
44. Remembering everything I could about the abuse. 1 2 3 4 5
45. Taking action against my offender. 1 2 3 4 5
46. Having a relaxing home environment as an adult. 1 2 3 4 5
47. Having a supportive partner. 1 2 3 4 5
48. Connecting with other survivors. 1 2 3 4 5
49. Finding creative ways to express myself. 1 2 3 4 5
50. Overcoming my own denial about having been abused. 1 2 3 4 5
51. Forgiving my offender. 1 2 3 4 5
52. Being loved by others. 1 2 3 4 5
53. Learning that the abuse was not my fault. 1 2 3 4 5
54. Reconnecting with my feelings. 1 2 3 4 5
55. Being surrounded by healthy influences away from home when I 1 2 3 4 5
56. Telling my story. 1 2 3 4 5
57. Quitting the use of drugs and/or alcohol. 1 2 3 4 5
58. Understanding how the abuse changed my life. 1 2 3 4 5
59. Participating in spiritual practices or rituals. 1 2 3 4 5
60. Accessing support networks during times of crisis. 1 2 3 4 5
61. Finding personal strengths that resulted from having been abused. 1 2 3 4 5
62. Being believed. 1 2 3 4 5
63. Dealing with my offender's denial. 1 2 3 4 5
64. Speaking out about the abuse to protect other potential victims. 1 2 3 4 5
65. Gaining knowledge about sexual abuse. 1 2 3 4 5
66. Being protected from the offender when I disclosed the abuse. 1 2 3 4 5
67. Learning to be open in my relationships. 1 2 3 4 5
68. Doing journaling. 1 2 3 4 5
69. Putting the abuse into perspective. 1 2 3 4 5

Appendix K: Instructions for Labelling Process

Thank you so much for agreeing to help me with this! For each of my three questions, I have enclosed a "map" and a table that lists each "cluster".

What I need you to do is:

1) Label each cluster. To do this, look at the statements in each cluster and see what description or label or theme would summarize all or most of the statements. When possible, it is best to use the language of the statements included in the cluster. Also, you will notice the statements are listed in order of "bridging values" with the lower bridging values being listed first. The lower the bridging value, the more relevant or central the statement is to the cluster (low = good) and the theme should be sure to represent the lowest values. Feel free to write your labels right onto the table.

2) Identify "map" themes (across & up and down). To do this, write the label you gave each cluster on the map near the appropriately numbered cluster (the big numbers are the cluster numbers). This will allow you to see where each cluster is on the map. Now, as you move from the left to right on the map (or right to left) is there a theme or pattern (e.g., from feelings to actions? from individuals to groups?). Secondly, as you move from top to bottom (or bottom to top), is there a theme or pattern? Write these themes on the map near the arrows. For example, it might look like this if there was a shift from individuals to groups as you moved from the bottom and then up the map and from feelings to actions as you moved from left to right across the map:

groups
feelings actions
individuals

3) Complete the following:

Age: ____ Gender: _______

Are you a survivor of Childhood Sexual Abuse? ______ (yes or no)

Reviewed Question #1 _____ Question #2______ Question #3 _______

Level of Education Completed:
did not graduate from grade 12 ______
completed high school _____
college graduate ______
university graduate ______
other: specify _________________________

Please return all this information to me ASAP!!!! Thanks so much!
Mary